STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. Box 420603
San Francisco, CA 94142

NOTICE OF PROPOSED RULEMAKING

The Administrative Director of the Division of Workers' Compensation proposes to adopt or amend the regulations described below after considering all comments, objections, and recommendations regarding the proposed action.

Please note that the Official Medical Fee Schedule and the Medical-Legal Fee Schedule "establish or fix rates, prices, or tariffs" within the meaning of Government Code Section 11343(a)(1) and hence are not subject to Article 5 of the Administrative Procedure Act (commencing at Government Code Section 11346.) Rather, promulgation of these schedules is under Labor Code Section 5307.1(a)(1). Nonetheless, the Administrative Director of the Division of Workers' Compensation gives this Notice of Proposed Rulemaking in voluntary compliance with the Administrative Procedure Act.

PROPOSED REGULATORY ACTIONS

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in him by Labor Code Sections 133, 139(e)(8), 4061.5, 5307.1 and 5307.6, proposes to amend or adopt these regulations:

1. Amendments to Sections 9791.1 and 9792 in Title 8 of the California Code of Regulations [CCR], including a document incorporated by reference: *Official California Workers' Compensation Medical Fee Schedule (Revised January 1, 1998).* These amendments will constitute the biennial revision of the Official Medical Fee Schedule required by Labor Code Section 5307.1.

2. Amendments to Sections 9790.1 and 9792.1 in Title 8 of the California Code of Regulations. These sections concern the Official Medical Fee Schedule as it applies to hospitals.

3. Amendments to Section 9795 in Title 8 of the California Code of Regulations. These amendments will constitute a revision of the Medical-Legal Fee Schedule as required by Labor Code Section 5307.6.

4. Deletion of Sections 9785 and 9785.5 in Title 8 of the California Code of Regulations; adoption of new Section 9785 and adoption of forms. These sections concern reporting requirements of physicians to claims administrators.

5. Amendments to Section 9792.6 in title 8 of the California Code of Regulations and adoption of forms. That section concerns "utilization review" --

the method by which claims administrators make and communicate decisions concerning the appropriateness of proposed medical treatment.

PUBLIC HEARING

Public hearings have been scheduled to permit all interested persons the opportunity to present statements or arguments, oral or in writing, with respect to the subjects noted above, on the following dates:

Date:	**November 24, 1997 - (Monday)**
Time:	**10:00 am to 5:00 PM or conclusion of business.**
Place:	**Public Utilities Commission - Auditorium** **505 Van Ness Ave.** **San Francisco, CA**
Date:	**November 25, 1997 - (Tuesday)**
Time:	**10:00 am to 5:00 PM or conclusion of business.**
Place:	**107 S. Broadway, Room 1138** **Los Angeles, CA**

Please note that public comment will begin promptly at 10:00 a.m. and will conclude when the last speaker has finished his or her presentation. If public comment concludes before the noon recess, no afternoon session will be held.

The Administrative Director requests, but does not require, that any persons who make oral comments at the hearing also provide a written copy of their comments.

AUTHORITY AND REFERENCE

The Administrative Director of the Division of Workers' Compensation, is undertaking this regulatory action pursuant to the authority vested in him as follows:

1. As to Title 8, Sections 9791.1 and 9792, Labor Code Section 5307.1 gives the Administrative Director authority to adopt and revise an Official Medical Fee Schedule. The Administrative Director has more general authority under Labor Code Sections 133, 4603.5 and 5307.3. Reference is Labor Code Sections 4600, 4603.2, and 5307.1.

2. As to Title 8, Sections 9790.1 and 9792.1, Labor Code Section 5307.1 gives the Administrative Director authority to adopt and revise an Official Medical Fee Schedule as it applies to health care facilities licensed pursuant to Section 1250 of the Health and Safety Code -- i.e., hospitals. The Administrative Director has more

general authority under Labor Code Sections 133, 4603.5 and 5307.3. Reference is to Labor Code Sections 4600, 4603.2, and 5307.1 and Health & Safety Code Section 1250.

3. As to Title 8, Sections 9795, Labor Code Section 5307.6 gives the Administrative Director authority to adopt and revise a fee schedule for medical-legal expenses as defined by Labor Code Section 4620. The Administrative Director has more general authority under Labor Code Sections 133, 4603.5, 44627 and 5307.3. Reference is to Labor Code Sections 4620 and 5307.6.

4. As to Title 8, Sections 9785 and 9785.5, Labor Code Section 4061.5 gives the Administrative Director authority to promulgate rules concerning the method by which primary treating physicians render opinions. The Administrative Director has more general authority under Labor Code Sections 133, 4603.5, 4627 and 5307.3. Reference is to Labor Code Sections 139, 4061.5, 4600, 4603.2 and 4636.

5. As to Title 8, Section 9792.6, Labor Code Section 139(e)(8) gives the Administrative Director authority to adopt model utilization protocols in order to provide utilization review standards. The Administrative Director has more general authority under Labor Code Sections 133, 4603.5, 4627 and 5307.3. Reference is to Labor Code Sections 129.5, 4062, 4600, 4603.2 and 5307.1.

INFORMATIVE DIGEST
AND PLAIN ENGLISH OVERVIEW AND SUMMARY

1. Proposed Amendments to Sections 9791.1 and 9792. Official Medical Fee Schedule

Labor Code Section 5307.1 requires the administrative director [AD] of the Division of Workers' Compensation [DWC] to "adopt and revise, no less frequently than biennially, an official medical fee schedule which shall establish reasonable maximum fees paid for medical services provided pursuant to [Division 4 of the Labor Code]." The Official Medical Fee Schedule [OMFS] was last revised in 1995.

The proposed amendments to the OMFS are to comply with Labor Code Section 5307.1. First, there is a small technical amendment to Section 9791.1 to properly incorporate the OMFS by reference. (The OMFS itself will exceed 300 closely printed pages and cannot be published in its entirety in the Code of Regulations.) The document to be incorporated is the *Official California Workers' Compensation Medical Fee Schedule (Revised January 1, 1998).* A copy of this document will be part of the rulemaking file and will be available for public inspection at the offices of the Division of Workers' Compensation, 45 Fremont Street, Suite 3160, San Francisco, California 94105.

More importantly, the proposed substantive amendments to the OMFS are based very largely on the work of the Official Medical Fee Schedule Task Force, a public advisory body convened by the Industrial Medical Council pursuant to Labor Code Section 139(e)(7) and the Administrative Director pursuant to Labor Code Section 5307.1(a)(3). The Task Force consisted of dozens of representatives of

insurers, employers, self-insured employers, labor, medical providers of all sorts, and other interested parties. The Task Force held monthly meetings -- and numerous sub-committee meetings -- from June 1996 through March 1997. The *Recommendation of Task Force on Official Medical Fee Schedule (March 1997),* including sub-committee reports and communications contained therein are a part of the rulemaking file.

In certain limited areas, the Administrative Director has not followed the Task Force's recommendations.

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Simply stated, the OMFS consists of three parts:

A. A series of code numbers and descriptions of particular medical procedures -- usually referred to as "CPT Codes."

B. A series of "relative values" that are associated with each CPT code.

C. A "conversion factor," which is a particular dollar amount, associated with different sections of the OMFS.

The reasonable maximum fee for medical services is determined by multiplying the relative value of a particular medical procedure by the appropriate conversion factor. For instance, for a flourescein angiography with multi-frame imaging (CPT Code 92235), the relative value is 27.4. Since Code 92235 is found in the "Medicine" section of the OMFS, the appropriate conversion factor is $6.15. The maximum fee is therefore 27.4 x $6.15 = $168.51. And that is what the physician would bill the payer. In addition, the OMFS contains various "ground rules," "instructions," and "modifiers" that physicians use in making their bills. For instance, if two surgeons work together on a single surgical procedure, each surgeon would add a "modifier" to the CPT Code when billing the payer. In this example the modifier would be *-62* .

A. The proposed CPT Codes, ground rules and modifiers are based almost entirely on *Physicians' Current Procedural Terminology CPT '97*, published and copyrighted in 1996 by the American Medical Association. That publication brings the CPT Codes up to date to reflect current medical procedures. In a few instances, the Administrative Director is proposing codes that are somewhat different from, or additional to, the *Physicians' Current Procedural Terminology CPT '97*.

B. Proposed amendments to relative values are made when a new CPT code is created or an old CPT code is modified, particularly when an old code is "unbundled." These amendments are based almost entirely on proprietary figures created by Medicode, Inc., under contract to the Industrial Medical Council. Notable among these are significantly reduced relative values for certain surgical procedures on the spine (CPT 22842 and 22845). The Administrative Director is proposing relative values for psychotherapy that are different from those put forward by

Medicode, Inc.: the RV will be raised for psychiatrists and some psychologists and lowered for MFCCs and LCSWs.

C. It is proposed to increase the conversion factor for evaluation and management services from $7.15 to $8.50. This is designed to reflect the greater demands placed on primary treating physicians in the 1993 workers' compensation reforms (Labor Code Section 4061.5 and 8 Cal. Code Regs. Section 9785.5.) Physicians treating industrial injuries and illnesses must have special skills and knowledge -- such as the skill and knowledge needed to render opinions on the ability of a patient to return to particular work -- that are unique to the workers' compensation system and should be appropriately reimbursed.

In addition, there are other proposed amendments to the OMFS. Some of the more notable amendments include these:

- Contracts between payers and providers would be altogether exempt from the OMFS.
- Osteopathic manipulation codes could be used only by DOs and MDs. Chiropractors would use only chiropractic manipulation codes.
- Reimbursement levels would be specified for many supplies and materials.
- Many required medical reports would be reimbursed.
- Reproduction of chart notes and reports would be reimbursed.
- There would be a code for missed appointments. However, this code would be "By Report" and would be only for communication purposes.
- When an interpreter is required, evaluation and management reimbursement would be increased.
- In physical medicine, reimbursement would be allowed for any four treatment methods, not only the two procedures plus two modalities allowed in the current OMFS.
- Reimbursement for hot and cold packs would be eliminated.

2. Proposed Amendments to Sections 9790.1 and 9792.1. Official Medical Fee Schedule as it relates to hospitals

One portion of the OMFS applies just to inpatient services -- that is, services performed by a hospital for a hospitalized patient. That portion of the OMFS, which is contained at Sections 9790.1 and 9792.1 is based on a different principle from the rest of the schedule. Namely, it is based on a "global fee" for services made in connection with particular "diagnosis related groups" [DRG]. Each DRG is assigned a "relative weight." Each hospital in the state is individually assigned a "composite factor" that recognizes that hospital's unique costs of operation. Some hospitals have high costs of operation (such as big-city, teaching hospitals). Other hospitals have lower costs (such as more rural, non-teaching hospitals). It is a requirement of Labor Code Section 5307.1(a)(1) that the fee schedule “take into consideration cost and service differentials for various types of facilities.”

The fee a hospital may charge is given by the following formula:

1.20 x relative weight of the particular DRG x composite factor

For instance, suppose Saint Rose Hospital performs a back surgery. The DRG for back surgery is 214 with a relative weight of 1.8627. The hospital's composite factor is 7,747. The hospital would be able to charge the payer 1.20 x 1.8627 x 7,747 = $17,316.40.

The hospital portion of the OMFS was promulgated by the Administrative Director in December 1996, to be implemented April 1997. In February 1997, the Administrative Director issued a set of *Instructions* that more fully explained the regulations, and provided a set of actual numbers for the composite factor of every hospital in the state. However, a lawsuit was brought against the Administrative Director in March 1997 to prevent implementation, and a Superior Court did issue an injunction against the Administrative Director (*CCN* v. *Young*; San Diego Superior Court No. 709283.)

The gist of the lawsuit was that the composite factors, as promulgated in 1996, were too vague and uncertain to be of practical use. The lawsuit also charged that the *Instructions* published in February 1997, though they were highly specific and therefore cured any uncertainty in the December regulations, were themselves defective because they were not the subject of public hearings.

In order to settle this lawsuit, the Administrative Director agreed to "notice proposed regulations and amendments to regulations to implement establishment of an inpatient hospital fee schedule pursuant to Labor Code Section 5307.1 for public hearing and comment, and allow public comment on all issues presented by the proposal."

The proposed amendments are put forward for public hearing and comment in order to comply with the settlement. The amendments address the concern of the lawsuit: namely, the uncertainty of the "composite factors" as promulgated in December 1996. The proposed amendments give fully detailed formulas for deriving the composite factors (Proposed Section 9790.1(a)(1) and (2)) and actually promulgate a full table of the composite factors for every hospital (Section 9790.1(a)(3). The proposed formulas and tables are identical to those found in the February 1997 *Instructions.* But through this rulemaking process, the formulas and tables are exposed to public comment and other aspects of rulemaking. The amendments would incorporate two documents by reference, both of which are available for inspection: that portion of *FY 1997 Prospective Payment System Payment Impact File (September 1996 Update)* that relates to California hospitals, and *Federal Register* of August 30, 1996 at Vol. 61, No. 170, page 46439;

In addition, two other amendments are proposed:

First, it is proposed to strike Section 9792.1(c) which now requires annual revision of the hospital portion of the OMFS. The effect of striking this section would be to make the revisions biannual, in accord with Labor Code Section 5307.1.

Second, it is proposed to add Section 9792.1(e) to provide a method by which an individual hospital may obtain correction of its composite factor because of an arithmetic error in its calculation.

3. Proposed Amendments to Section 9795. Medical-Legal Fee Schedule

Labor Code Section 5307.6 requires the administrative director to "adopt and revise a fee schedule for medical-legal expenses, as defined by Section 4620. . . at the same time he or she adopts and revises the medical fee schedule pursuant to Section 5307.1" Since the medical fee schedule is being revised now, this is the appropriate time to revise the medical-legal fee schedule.

Again, there was a task force, similar to the OMFS task force, a public advisory board that held numerous meetings. The Administrative Director follows its recommendations in their entirety, with one exception concerning missed appointments.

Proposed amendments include the following:

1. A code is created for missed appointments (ML100); but the code is for communication purposes only.

2. Reimbursement for follow-up evaluations (ML 101), now set at a flat rate of $250, would be billed by time, in 15-minute increments at $50 each.

3. Basic evaluations (ML102) are reimbursed at $500. Complex evaluations (ML103) and evaluations “involving extraordinary complexity” (ML104) are reimbursed at higher levels. Whether an evaluation is complex or extraordinarily complex (as opposed to basic) depends on the number of “complexity factors” involved in the evaluation. Under the present proposal, the number of available "complexity factors" would be increased. A new "complexity factor" would be allowed for a psychiatric or psychological evaluation. Two new "complexity factors" would allow aggregation of existing factors.

4. Proposed Amendments to Section 9785 and Deletion of Section 9785.5; Adoption of Forms. Reporting Requirements of Physicians to Claims Administrators

In the workers’ compensation system, there are numerous requirements concerning reports from physicians to claims administrators, including the Doctor’s First Report (DLSR Form 5021), the initial report and progress reports of an employee-selected physician, permanent and stationary reports from all physicians, as well as a vast variety of forms and reports required by claims administrators from employer-selected physicians. These reports are not only legal requirements, they are essential to communication between payers and providers. Since there are over 600 claims administrators in the State and hundreds of thousands of medical providers, clear methods of communication, understood by all parties, are vital..

There is a pressing need for order and uniformity – in a word, for *simplification*.

The present proposal would consolidate two important reporting regulations: 8 Cal. Code Regs. Section 9785 (which applies to employee-selected physicians) and Section 9785.5 (which applies to primary treating physicians). The proposal would require all physicians, however selected, to make the same reports. It would require detailed treatment plans in all reports. And it would provide a new form – the "Physician's Progress Report of Treatment of Occupational Injury or Illness" (DWC Form PR-2) – which is a simple, one-page form containing the most essential information needed in a progress report. In case a longer, narrative report is needed, Form PR-2 will be a useful cover sheet, clearly identifying the parties and the purpose of the report. A new Form PR-3 is provided (but not required) for permanent and stationary reports by the primary treating physician. The present proposal would also require claims administrators to accept reports by FAX.

5. Proposed Amendments to Section 9792.6; Adoption of Forms. Utilization Review.

Labor Code Section 139(e)(8) mandates the Administrative Director to "adopt model utilization protocols in order to provide utilization review standards." He did so in 1995 by adopting 8 Cal. Code Regs. Section 9792.6.

"Utilization review" [UR] is a system whereby physicians request authorization to proceed with certain medical treatment and claims administrators either grant or deny the authorization. The only issue in UR is whether the proposed treatment is medically necessary. (Issues about the compensability of the underlying workers' compensation claim is handled differently.) The essential feature of the system, which would be unchanged by the present proposal, is that a claims administrator may not deny a request for authorization until it has been reviewed by a physician using medically-based criteria. In other words, medical decisions must be based on medical criteria and must be made by medical personnel. A medically untrained claims adjuster may not overrule a medical decision made by a physician who has actually examined the patient.

That much is clear. But nearly all other aspects of the UR system, as it is now set forth at Section 9792.6, are unclear. After two years of experience, many important questions about the system remain unresolved. The purpose of the proposed amendments to Section 9792.6 is to answer some of the more important questions. Briefly summarized, the questions and answers are as follows:

+ *What is the relationship between the UR system and the medical-legal system in Labor Code Section 4062?* Labor Code Section 4062 proceedings remain an option for the parties, and may ultimately have to be invoked if the UR process fails to resolve medical disputes. But the primary purpose of UR is to avoid medical-legal procedures by encouraging communication between the treating and reviewing physicians. The proposed UR regulations are designed to formalize and regularize communication between the parties so that disputes are resolved quickly and without the need for litigation.

+ *What is the effect of a claims administrator's failure to respond to a request for authorization?* When a claims administrator fails to respond to a request for authorization or treatment plan, authorization is presumed.

+ *What is the effect of a physician's failure to respond to an administrator's request for more information or an initial assessment that the requested treatment may not be medically necessary?* When a physician fails to respond to an administrator's request for more information, or its initial assessment that the proposed treatment is not medically necessary, withdrawal of the request is presumed. In other words, when an administrator informs the physician that the proposed treatment appears to be unnecessary, the physician's failure to respond will be construed as agreement with the assessment.

+ *May an administrator authorize some parts of a treatment plan and deny others?* When a physician requests authorization for a series of treatments – such as repeated physical therapy or psychotherapy sessions – the administrator may authorize treatments for a reasonable length of time, requiring the physician to request or justify extensions of the time.

+ *What is the place of telephone requests in the UR system?* Telephone requests are permitted, but do not relieve the physician of other reporting duties. If the administrator grants a telephone request, the administrator must, on the physician's request, either give a unique confirmation number or supply a written confirmation within two days.

The proposal also mandates the use of several forms for claims administrators to use when denying requests for authorization or when asking the physician for more information.

STATE REIMBURSABLE MANDATE

The Administrative Director of the Division of Workers' Compensation has determined that the proposed regulations will not impose any new mandated programs on any local agency or school district.

COST OR SAVINGS TO LOCAL AGENCIES, SCHOOL DISTRICTS AND STATE AGENCIES

The changes proposed here will impose no additional costs or savings on the operation of any local agency, school district or state agency. However, to the extent that such districts and agencies are employers who must reimburse physicians and hospitals for medical treatment of industrially injured employees and must incur medical-legal expenses, they will be subject to the same cost impacts as all other medical payers in the state. These impacts are discussed in more detail in the "Potential Economic Impact" section of this Notice. However, the cost impacts on governmental agencies as self-insured employers may be summarized as follows:

+ As to payments to medical providers under the OMFS, there will be an estimated aggregate increase of 1.67% or 3.48%, depending on the baseline used for the estimate.

Approximately 58% of all medical costs in the workers' compensation system are payments to medical providers under the OMFS. Therefore, the maximum impact on all medical costs would be .58 x .0348 = .020 – which is an increase of 2%.

+ As to payments to hospitals under the OMFS, there will be an estimated decrease in medical costs of approximately 24%. Approximately 24% of all medical costs are payments to hospitals. The maximum impact on all medical costs would therefore be .24 x .24 = .0576 – which is a decrease of 5.76%.

+ As to payment for medical-legal evaluations, there will be a small increase, very difficult to calculate. One estimate, based on hypothetical assumptions, shows an increase of 3.2%. Approximately 6% of all medical costs are medical-legal. The maximum impact on all medical costs would therefore be .032 x .06 = .00192 – an increase of .2%. Even if the medical-legal impact were twice what is estimated here, the impact would be an increase of .4% on all medical costs.

+ It is anticipated that all medical costs affected by these schedules (payment to physicians, payment to hospitals and payment for medical-legal evaluations), when considered together, will decrease. The increase in payments to physicians will be outweighed by the decrease in payments to hospitals.

+ As to changes in reporting requirements under proposed Section 9785, there will be no impact on costs or savings.

+ As to changes in utilization review proposed under Section 9792.6, it is anticipated there will be savings, in an unknown amount, due to decreased usage of medical-legal procedures.

+ The proposed amendments will have no impact on federal funding.

POTENTIAL ECONOMIC IMPACT ON BUSINESS

The Administrative Director finds that adoption of these regulations may have a significant economic impact on businesses, both adverse and beneficial. The Administrative Director does not find any effect on the ability of California businesses to compete with businesses in other states. The Administrative Director has not yet considered proposed alternatives that would lessen any adverse economic impact. Submissions may include the following considerations:

(i) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to businesses.
(ii) Consolidation or simplification of compliance and reporting requirements for businesses.
(iii) The use of performance standards rather than prescriptive standards.
(iv) Exemption or partial exemption from the regulatory requirements for businesses.

What follows is a description of the potential economic impacts of the present proposals, including identification of the types of businesses that would be affected, and of the projected reporting, recordkeeping and other compliance requirements that would result from the proposed action.

+ As to payments to medical providers under the OMFS (Sections 9790.1 and 9792)

A fiscal analysis has been prepared by the Administrative Director, dated September 15, 1997. The analysis concerns payments to physicians under the OMFS, which is approximately one-half of all medical costs in the workers' compensation system. The analysis uses two different "baselines" for estimating current medical costs under the OMFS. One baseline is based on paid costs as reported to the Workers' Compensation Insurance Rating Bureau. The other is based on charge data compiled by the California Workers' Compensation Institute.

The analysis estimates the impact of the more significant changes made in the proposed OMFS, including:

+ Increase of the Evaluation and Management conversion factor to $8.50, and reimbursement for use of an interpreter in evaluation and management.
+ Changes in the Physical Medicine Codes to permit any four procedures to be used on a single day; elimination of generic manipulation codes; elimination of payment for use of hot or cold packs.
+ Use of separate rates for physicians and non-physicians in psychotherapy.
+ Changes in RVs for nerve conduction studies, EMGs, and biofeedback.
+ Changes in RVs for certain surgical procedures on the spine.
+ Making most physicians' reports reimbursable and providing for reimbursement of chart notes and duplicate reports.
+ Change in the structure of reimbursement for materials and supplies.

It is estimated that, in aggregate, these changes will raise reimbursement levels under the OMFS by 1.67%, if one uses WCIRB figures as a baseline – or 3.48%, if one uses CWCI figures as a baseline. These increases are "adverse" to payers; but, to the exact same extent, they are beneficial to medical providers.

+ As to payments to hospitals under the OMFS (Sections 9790.1 and 9792.1):

Although the proposed amendments to the hospital fee schedule concern only a more complete definition of "composite factors," we here discuss the fiscal impact of the hospital fee schedule as a whole. That is because application of the hospital fee schedule as a whole was stayed as a result of the litigation discussed above. The practical effect of this rulemaking process will therefore be to implement the hospital fee schedule for the first time. We therefore discuss the entire fiscal impact.

The Institute of Health Policy Studies of the University of California recommended use of a Medicare model [composite factors x DRG weights or revised DRG weights.] The Institute recognized that such a model would generate fees substantially lower than those received by hospitals now for workers' compensation services. In order to assess the impact of the new schedule on payments to hospitals, the Institute calculated a "budget

neutral adjustment factor" – or multiplier. The purpose of the multiplier was "to attempt to make total hospital reimbursement under the DRG-based Workers' Compensation reimbursement system equal hospital reimbursement under the old system." (*Final Report* Module 3, page 1.)

To calculate the multiplier, the Institute used CWCI data for 1989 - 1993 for 48 high-volume workers' compensation DRGs. It calculated "actual workers' compensation payments across all 48 DRGs." The Institute then compared these actual payments to payments using Medicare DRG weights as *revised* to account for differences between the Medicare population and the population using the California workers' compensation system. In its *Final Report* at Module 3, page 2, the Institute stated, "According to this [method], in order for hospitals to receive as much payment for their services under the new system as they did under the old system, the maximum inpatient rate schedule would have to be set at 157% of the Medicare DRG payment schedule, where that schedule incorporated the new DRG weights that we [have] calculated."[i]

In other words, using a Medicare DRG model with revised DRGs, a multiplier of 1.57 would be needed to maintain hospital fees at their current level. In fact, the Administrative Director used a multiplier of only 1.20 in order to *lower* costs to payers over all, and to bring workers' compensation medical costs more in line with non-workers' compensation costs. The result of using a multiplier of 1.20 (instead of 1.57) will be to reduce hospital costs from their present level by a factor of 24%.

This 24% reduction in hospital fees in the workers' compensation system would have an adverse economic impact on California hospitals. (However, the fees are still significantly higher than the fees those same hospitals would receive under Medicare.) The 24% reduction in hospital fees would have a correspondingly beneficial economic impact on workers' compensation payers.

+ <u>As to payments for medical-legal evaluations (Section 9795):</u>

The addition of a code for missed appointments will have no fiscal impact, since it is created for communication purposes only and does not in itself require reimbursement.

The change in reimbursement for follow-up evaluations from the present flat fee of $250 to a time-based fee of $50 for each 15 minutes may have some slight impact; but the degree or direction of the impact cannot yet be determined. In some instances, the fee for follow-up evaluations will decline slightly. In others, it will increase. The final impact will depend on the average length of follow-up evaluations. If they average 75 minutes or less, fees will remain the same or decrease. If they average more than 75 minutes, fees will increase. The Task Force participants presented no hard data on the subject. However, since follow-up reports constitute only 6.4% of all medical-legal reports (according to a January 1997 study by Ernst & Young commissioned by CWCI), any economic impact on payers is likely to be minimal.

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[i] It should be noted that the Institute itself expressed reservations about the data it relied on and its own methods of comparison.

The potential increase attributable to additional "complexity factors" is likewise difficult to assess. 64.4% of all reports are now "basic" (ML102) and 15.8% are "complex' (ML103). With more "complexity factors" available to physicians, the percentage of complex reports will increase somewhat; but, again, Task Force participants presented no hard data On the hypothetical assumption that 10% of all ML102 reports will be "bumped up" to the status of ML103, the fees for 6.44% of all reports would increase by 50% (from $500 to $750) – for a total increase of 3.2%. 15.8% of all reports are now "complex" (ML103). It is likely that some ML103 reports will be bumped up to ML104. However, data shows there is almost no difference in actual payment between ML 103 and ML 104 (an average cost of $781 compared to $796). The fiscal impact of any shift from ML103 to ML104 will be close to negligible.

In sum, the main fiscal impact of changes to the Medical-Legal Fee Schedule will likely come from the greater number of available "complexity factors." These will likely increase costs by a fraction over 3%. To payers, this impact would be "adverse." To medical providers, it would be beneficial.

+ <u>As to simplification of medical reporting requirements (Sections 9785 and 9785.5):</u>

Except for a brief period in which physicians and providers will need to learn the new Form PR-2, there will be cost savings to both physicians and claims administrators through the use of standard, simplified report forms. The savings will be difficult to quantify.

+ <u>As to changes in the utilization review system (Section 9792.6):</u>

Except for a brief period in which claims administrators and physicians will need to learn the use of new forms, there will be cost savings to both physicians and claims administrators through the avoidance of medical-legal procedures and lien disputes. The savings will be difficult to quantify.

COST IMPACT ON PRIVATE PERSONS AND BUSINESSES:

+ To the extent that private persons and entities are self-insured employers, who must themselves directly reimburse medical providers, the cost impact is the same as on self-insured governmental agencies, as discussed in the section entitled "Costs or Savings to Local Agencies, School Districts and State Agencies."

+ Workers' compensation insurers, likewise, will be subject to the costs and savings discussed above.

+ Private persons who are physicians receiving payment under the OMFS and the MLFS will, in aggregate, enjoy a beneficial economic impact to the same extent that payers will suffer an adverse impact.

+ Hospitals will suffer an adverse economic impact to the same extent payers will enjoy a beneficial impact.

+ The replacement of a multitude of reporting requirements with a few, standard, simple forms will result in cost savings to physicians and claims administrators, but an unknown amount.

+ Improvements in the utilization review system will result in cost savings to physicians and claims administrators, but an unknown amount.

ASSESSMENT OF EFFECTS ON JOB AND/OR BUSINESS CREATION, ELIMINATION OR EXPANSION

The Administrative Director has determined that the proposed regulations will not affect the creation or elimination of jobs within the State of California, the creation of new businesses or the elimination of existing jobs within the State of California, or the expansion of existing businesses within the State of California.

IMPACT ON HOUSING COSTS

The Administrative Director has determined that the proposed regulations will have no effect on housing costs.

PLAIN ENGLISH REQUIREMENTS CONCERNING SMALL BUSINESSES

The Administrative Director has determined that the proposed regulations affect small businesses. The Administrative Director has determined that it is not feasible to draft the regulations in plain English due to the subject matter and the technical nature of the regulations proposed,. The "Informative Digest" above constitutes a plain English policy statement overview and a noncontrolling plain English summary. A copy of this Notice of Proposed Rulemaking, including the "Informative Digest," is available from the contact person named below.

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code Section 11346.5(a)(12), the Administrative Director must determine that no alternative he considered would be more effective in carrying out the purpose for which the actions are proposed or would be as effective and less burdensome to affected private persons than the proposed action.

The Administrative Director invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

AVAILABILITY OF STATEMENT OF REASONS

An Initial Statement of Reasons has been prepared for the proposed amendments, in addition to the Informative Digest included in this Notice. The Initial Statement

of Reasons will be made available for inspection at or provided upon written request. Please direct all requests to the contact person identified below.

PRESENTATION OF ORAL AND/OR WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS

Members of the public are invited to present oral and/or written statements, arguments or evidence at the public hearing. In addition, any person may submit written comments on the proposed regulations, prior to the public hearing to:

Ms. Aurora Medina
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

Unless submitted prior to or at the public hearing, all written comments must be received by the agency contact person, no later than 5:00 p.m. on November 25, 1997. Equal weight will be accorded to oral and written materials.

AVAILABILITY OF TEXT OF PROPOSED REGULATIONS

The complete text of the proposed amendments, including all documents incorporated by reference, will be made available for inspection or provided upon written request and payment of a copying fee. Please direct all requests to the contact person identified below.

AVAILABILITY OF RULEMAKING FILE

The rulemaking file, including all documents relied upon, will be made available for inspection or provided upon written request and payment of a copying fee. Please direct all requests to the contact person identified below.

LOCATIONS WHERE DOCUMENTS MAY BE INSPECTED

The Initial Statement of Reasons and the complete text of the proposed regulations, including documents incorporated by reference may be inspected at the following locations during normal business hours:

Division of Workers' Compensation
45 Fremont Street, Suite 3160
San Francisco, California 94105

Workers' Compensation Appeals Board
107 South Broadway, Room 4107
Los Angeles, California 90012

Workers' Compensation Appeals Board
2424 Arden Way, Suite 230
Sacramento, California 95825

The rulemaking file may be inspected during normal business hours at:

Division of Workers' Compensation
45 Fremont Street, Suite 3160
San Francisco, California 94105

CONTACT PERSON

Any interested person may inspect a copy or direct questions about the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file. The rulemaking file will be available for inspection at the Division of Workers' Compensation, 45 Fremont Street, Room 3160, San Francisco, CA 94105, between the hours of 9:00 a.m. and 4:30 p.m., Monday through Friday. Copies of the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be requested in writing at the same address. The contact person is:

Ms. Aurora Medina
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

The telephone number of the contact person is (415) 975-0700.

AVAILABILITY OF CHANGES FOLLOWING PUBLIC HEARING

If the Administrative Director makes changes to the proposed regulations as a result of the public hearing and public comment received, the modified text with changes clearly indicated will be available for public comment for at least 15 days prior to the date on which the regulations are adopted. There are no statutory or other notice requirements other than those contained in the Administrative Procedures Act, (Government Code section 11340, *et seq.*,) applicable to the adoption of these proposed regulations.

AUTOMATIC MAILING

A copy of this Notice, including the Informative Digest, will automatically be sent to those interested persons on the mailing list of the Administrative Director of the Division of Workers' Compensation.

If adopted, the regulations as amended will appear sequentially in the California Code of Regulations at Title 8, Chapter 4.5, Subchapter 1, commencing with Section 9710.

Dated: _____

_____
Administrative Director,
Division of Workers' Compensation

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

INITIAL STATEMENT OF REASONS:

PROPOSED CHANGES TO PHYSICIANS' REPORTING REQUIREMENTS TITLE 8, CALIFORNIA CODE OF REGULATIONS SECTIONS 9785 and 9785.5

Problem Addressed by Proposed Action

The workers' compensation system requires a great variety of reports from physicians to claims administrators. All physicians must file a "Doctor's First Report of Occupational Illness or Injury" (Labor Code Section 6409; DLSR Form 5021.) Employee-selected physicians must file an initial examination report (8 Cal. Code Regs. Section 9785(b).) Employee-selected physicians must file periodic reports, either time- or event-triggered (Labor Code Section 4603.2; 8 Cal. Code Regs. Sections 9785(c) and (d).) Physicians must file "permanent and stationary reports" (8 Cal. Code Regs. Sections 9785(e) and 9785.5(d). Further, "primary treating physicians" must "render opinions on all medical issues" (Labor Code Section 4061.5). There are yet other reports a physician might be called upon to make, such as consultation reports or disability status reports (Labor Code Section 4636; 8 Cal. Code Regs. Section 10124.) Further, utilization review may enable, or require, physicians to file "requests for authorization" (Labor Code Section 139(e)(8); 8 Cal. Code Regs. Section 9796.2.) And the Official Medical Fee Schedule itself has requirements for pre-authorization for certain procedures, which implies a communication of some sort from physician to claims administrator (Labor Code Section 5307.1.)

It is not only the sheer number of these reports that causes difficulties and confusion. A physician may not always be aware – or may easily forget – whether he or she is "employee-selected," which is a fact that determines what reports are required. Most physicians are also part of medical groups of one sort or another which may have their own internal reporting requirements. In addition, there are over 600 claims administrators in the State of California (workers' compensation insurers, third party administrators, etc.) who may impose, or attempt to impose, the use of particular forms on the physicians they deal with. And on the flip side, there are literally hundreds of thousands of medical providers in the State from whom the claims administrators must try to obtain reports. These reports are not merely legal requirements – they are the essential method for communication between claims administrators and physicians.

The situation is bewildering and cries out for order and uniformity. Above all, there is a need for *simplification*. There must be some attempt to have system-

wide forms of communication – well understood by all physicians and all claims administrators.

Purpose and Basis of Proposed Action

The present proposal is a first step to bring about the simplification so badly needed by all participants in the workers' compensation system. It is proposed:

+ To eliminate the distinction between employee-selected physicians and others. All primary treating physicians will be required to make the initial report and periodic reports now demanded only of employee-selected physicians. As a practical matter, employer-selected physicians must make similar reports even now; but they do so following the requirements and using the forms imposed by hundreds of different claims administrators.

+ To require all physicians to make detailed treatment plans, starting with the "Doctor's First Report" and continuing with required periodic reports.

+ To require all physicians to submit "progress reports" when significant medical events occur (such as when the employee's condition unexpectedly changes, when there is a need for a referral or hospitalization, or when there is a change in treatment plan.) In the absence of significant events, progress reports would still be required every 45 days while treatment continues.

+ These progress reports would be made on a simple one-page form (DWC Form PR-2.) Obviously, there are many situations requiring rather lengthy narrative reports. But in those cases, the PR-2 is designed to work as a face-sheet, clearly identifying the parties and the purpose of the report. In theory, if there were a contract between the claims administrator and the physician, the claims administrator could insist on additional reports made on yet other forms of the administrator's own devising – but it is hoped that the PR-2 will become an industry standard, creating a standard format for reports from physicians to claims administrators.

+ A new form is provided for making permanent and stationary reports (Form PR-3). The form is designed to guide the physician through the initial report on permanent disability. Use of the form will not be mandatory.

+ Reports could be submitted by FAX; and claims administrators will be required to maintain adequate FAX facilities. Electronic transmission of reports will be permitted, but not required.

Documents Relied Upon

None.

Specific Technology or Equipment

This proposal will not mandate use of specific technologies or equipment, except that claims administrators would be required to maintain FAX machines to receive reports from physicians.

Alternatives to the Regulation

No alternatives to the amendments proposed have yet been identified or considered by the Administrative Director. It is the purpose of the present rulemaking process to solicit and consider alternatives.

Identified Alternatives that Would Lessen Adverse Impact on Small Businesses

It is not anticipated that there will be any adverse impact on small businesses. No alternatives which would lessen the impact have been identified or considered by the Administrative Director.

Evidence Supporting Finding of No Significant Adverse Economic Impact on Any Business

The consolidation of reporting requirements and the use of standard forms may cause some temporary inconvenience to physicians and claims administrators as they learn to use new forms. However, since the proposed standard forms merely replace reports now being made in any event, the Administrative Director has determined that there will be no significant adverse economic impact on either physicians or claims administrators. On the contrary, there may be a significant beneficial impact through improved communications.

PROPOSED CHANGES TO THE OFFICIAL MEDICAL FEE SCHEDULE AS IT APPLIES TO HOSPITALS TITLE 8, CALIFORNIA CODE OF REGULATIONS SECTIONS 9790.1 and 9792.1

The Administrative Director of the Division of Workers' Compensation proposes to amend the Official Medical Fee Schedule for services provided by health care facilities licensed pursuant to Section 1250 of the Health and Safety Code [Inpatient Fee Schedule]. In particular, it is proposed to amend 8 California Code of Regulations Sections 9790.1 and 9792.1.

Please note that the Official Medical Fee Schedule "establishes or fixes rates, prices, or tariffs" within the meaning of Government Code Section 11343(a)(1) and hence is

not subject to Article 5 of the Administrative Procedure Act (commencing at Government Code Section 11346.) Rather, promulgation of the Official Medical Fee Schedule is under Labor Code Section 5307.1(a)(1). Nonetheless, the Administrative Director of the Division of Workers' Compensation gives this Initial Statement of Reasons in voluntary compliance with the Administrative Procedure Act.

Problem Addressed by Proposed Action

Labor Code Section 4600 requires employers to provide medical services to their employees for industrial injuries. In 1953, the Legislature enacted Labor Code Section 5307.1 enabling the Industrial Accident Commission to adopt "an official medical fee schedule." Responsibility for the fee schedule is now given to the Administrative Director. In 1993, Section 5307.1 was amended to require that hospital services be included in the fee schedule. That is, the Administrative Director was required "to establish reasonable maximum fees paid for medical services. . . *[including] services for health care facilities licensed pursuant to Section 1250 of the Health and Safety Code.* . ." i.e., hospitals.

In order to set a fee schedule for hospitals, the Administrative Director commissioned a study by the Institute of Health Policy Studies of the University of California, San Francisco. The Institute issued its study on November 7, 1995. It was entitled *Diagnosis-Related Group Reimbursement Methods for Workers' Compensation Hospital Stays (Final Report).* That study and the background material for it will be made available at the public hearings and will be part of the administrative record for this amendment.

Based on the study, the Administrative Director held public hearings on proposed new regulations: 8 Cal. Code Regs. Sections 9790.1 and 9792.1. Considerable written comment by the public was also considered. On December 31, 1996, the Administrative Director adopted Sections 9790.1 and 9792.1.

The reimbursement formula was set forth in Section 9792.1(a), as follows:

> **Maximum reimbursement for inpatient medical services shall be determined by multiplying 1.20 by the product of the health facility's composite factor and the applicable DRG weight or revised DRG weight if a revised weight has been adopted by the administrative director. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a health facility for inpatient medical services not exempted under this section. However, preadmission services rendered by a health facility more than 24 hours before admission are separately reimbursable.**

This formula may be restated, in somewhat simplified form, as follows:

> **1.20 x Composite Factor x DRG Weight (or revised DRG weight)**

In January 1997, the Administrative Director published *Instructions for Payment of Inpatient Hospital Bills*. This document gave a more detailed explanation of the formula used to calculate "composite factors." It also provided texts of the regulations, a complete table of DRG Weights, and a complete table of California hospitals with the composite factor for each.

On March 28, 1997, Community Care Network, Inc. [CCN] filed suit against the Administrative Director in the San Diego Superior Court. The suit alleged that the formula for "composite factors" contained in Section 9790.1(a) was "incomplete" and could not actually be used to calculate the "composite factors." The suit also alleged that the January 1997 *Instructions*, which gave an exact "composite factor" for every California hospital, were defective in that the *Instructions* themselves had not been the subject of public hearings. The Superior Court issued a temporary restraining order the Administrative Director from "computing, administering, or implementing the Instructions" (*CCN, Inc.* v. *Casey Young* Case No. 709283.)

In the litigation, the Administrative Director disputed (and still disputes) allegations that the regulatory formula was incomplete or that the *Instructions* were defective. In addition, the Administrative Director argued that the Superior Court lacked jurisdiction to review his regulations.

The Superior Court accepted the Administrative Director's jurisdictional argument and entered judgment against CCN. CCN filed an appeal and a petition for extraordinary writ with the Court of Appeal. The Court of Appeal denied the writ. CCN then appealed to the Supreme Court.

While that appeal was pending, CCN and the Administrative Director entered into a settlement: The lawsuit was dropped; but the *Instructions* would no longer be in effect. Further, the Administrative Director agreed to "notice proposed regulations and amendments to regulations to implement establishment of an inpatient hospital fee schedule pursuant to Labor Code Section 5307.1 for public hearing and comment, and allow public comment on all issues presented by the proposal."

Summary of Proposed Action

The proposed amendments fall into three groups:

1. The formula for determining "composite factors" is given in complete detail. A table of composite factors is actually made part of the text.

2. The regulation requiring annual revision of the inpatient fee schedule is struck. The effect would be to require revision along with the rest of the Official Medical Fee Schedule -- i.e., biannually.

3. A sub-section is added to give hospitals a procedure to correct arithmetic errors in the calculation of their composite factors.

Purpose and Basis of Proposed Action:
Complete Definition of "Composite Factors

As stated above, the reimbursement formula, as stated at Section 9792.1, is:

1.20 x Composite Factor x DRG Weight (or revised DRG weight)

This formula was promulgated in 1996 and is not the subject of these amendments -- except for the definition of "composite factor." The formula is based on the Medicare reimbursement model for inpatient services by health facilities. The fee schedule provides a global fee for inpatient services which takes into consideration cost and service differentials of various facilities. 48 Medicare Diagnostic Related Groups are revised to reflect the different resource usage between the workers' compensation population and the Medicare population. "Composite factors," which are uniquely assigned to each hospital in the state, are necessary to comply with the statutory mandate that the fee schedule "take into consideration cost and service differentials for various types of facilities." (Labor Code Section 5301.1(a)(1).)

Without conceding the validity of any argument suggesting that the original "composite factor" formula in Section 9790.1(a) was "incomplete" as originally promulgated in 1996, the Administrative Director is re-publishing the composite factor formula in complete detail. This is being done to implement the settlement agreement In *CCN, Inc.* v. *Young.* This proposal will not make any substantive change from the 1996 regulation or the *Instructions.* On the contrary, the only effect of the proposed amendment will be to make the *Instructions* an integral part of the regulations.

Section 9790.1(a): The definition of "composite factor" is made explicit, with full definitions by reference to Medicare sources. In particular, "prospective operating costs" and "prospective capital costs" are defined by formulas. The purpose of using Medicare-based composite factors is to recognize that some hospitals will have higher costs for performance of the same medical procedures. For instance, a hospital in a large city will likely have higher labor costs or land-use costs than a similar hospital in a rural setting. For another instance, some hospitals have costs associated with the socially valuable service of teaching medical students. If a non-teaching rural hospital received exactly the same payment for a procedure as an urban teaching hospital, either the former would be receiving a windfall or the latter would be suffering a loss. Medicare therefore makes a variety of adjustments to its reimbursements based on wages, geographical setting, whether the hospital is an educational institution, etc. The formula for "composite factors" given in these proposed regulations closely tracks the Medicare formulas.

Section 9790.1(a)(1) gives the following formula for "prospective capital costs":

> **Capital standard federal payment rate x capital wage index x large urban add-on x [1 + capital disproportionate share adjustment factor + capital indirect medical education adjustment factor]**

This formula was recommended by the Institute of Health Policy Studies at Module 3, page 5 and 6. The Institute of Health Policy Studies used a study entitled *Use of DRGs by Non-Medicare Payers*, published in February 1994 by the Rand/UCLA/Harvard Center for Health Care Financing Policy Research, pages 3 and 4. It is essentially identical to the formula used by HCFA for Medicare payments, found at 42 CFR Section 412.312(a).

Section 9790.1(a)(2) gives the following formula for "prospective operating costs":

> **[(Labor-related national standardized amount x operating wage index) + nonlabor-related national standardized amount] x [1 + operating disproportionate share adjustment factor + operating indirect medical education adjustment]**

This formula, too, was recommended by the Institute of Health Policy Studies at Module 3, page 5. The Institute of Health Policy Studies used a study entitled *Use of DRGs by Non-Medicare Payers*, published in February 1994 by the Rand/UCLA/Harvard Center for Health Care Financing Policy Research, pages 3 and 4. This formula is somewhat simplified from Medicare:

The first square-bracketed portion is a restatement of the formulas found at 42 CFR 412.63(r) and (s).

The second square-bracketed portion makes individual adjustments for the type of hospital involved. HCFA adjusts prospective operating costs for a larger variety of factors. See 42 CFR Section 412.90 et seq. For instance, it makes adjustments for such factors as whether the hospital is a teaching hospital (Section 412.106) and whether it receives a disproportionate share of low-income patients (Section 412.106). Those two adjustments are made in the formula given above. However, HCFA also makes adjustments for such factors as whether the hospital is a Christian Science sanitarium (42 CFR Section 412.92) or a renal transplantation center (42 CFR Section 100), etc.. These factors have relatively little relation to medical care for industrial injuries and have been excluded from the composite factor formula.

Section 9790.1(a)(3) is added to give a complete table of the actual composite factor for each hospital in California.

Section 9790.1(b) is amended to add a complete list of DRG weights.

Section 9790.1(h) is added to provide a definition of "Payment Impact File" and to incorporate it by reference. The Payment Impact File is the source of data -- the hospital-specific numbers -- that are used to calculate the actual composite factor for each hospital.

Purpose and Basis of Proposed Action: Biennial Revision

Section 9792.1(c), which now requires annual revision of the hospital fee schedule, is struck. Labor Code Section 5307.1 requires revision "no less frequently than biennially." It is the Administrative Director's intention to update the entire Official Medical Fee Schedule as a whole, no less than once every other year. The Administrative Director will comply with Section 5307.1 by putting any revisions that might be made through the administrative rule-making process.

Purpose and Basis of Proposed Action: Method for Correcting Arithmetic Errors

Section 9792.1(e) is added to provide a method for a hospital to obtain a correction of its composite factor when there has been an arithmetic error in its calculation.

Documents Incorporated by Reference

+ That portion of *FY 1997 Prospective Payment System Payment Impact File (September 1996 Update)* that relates to California hospitals

+ *Federal Register* of August 30, 1996 at Vol. 61, No. 170, page 46439

Documents Relied Upon

The proposed regulations incorporate by reference the following documents:

1. *Diagnosis-Related Group Reimbursement Methods for Workers' Compensation Hospital Stays (Final Report)* and background material, including *Use of DRGs by Non-Medicare Payers*, published in February 1994 by the Rand/UCLA/Harvard Center for Health Care Financing Policy Research;

2. That portion of *FY 1997 Prospective Payment System Payment Impact File (September 1996 Update)* that relates to California hospitals.

3. *Federal Register* of August 30, 1996 at Vol. 61, No. 170, page 46439;

4. DWC, *Instructions for Payment of Inpatient Hospital Bills (January 1997).*

5. The entire record in *Community Care Network, Inc.* v. *Casey Young, et al.* (San Diego Superior Court No. 709283.)

6. The following documents contained in file folders:

#1 Inpatient Hospital Fee Schedule

- ¥ 12 Steps: How to Calculate Hospital Composite Factors
- ¥ Inpatient Hospital Fee Schedule Policies and Procedures
- ¥ 1997 Prospective Payment System Payment Impact File (September 1996 Update)
- ¥ FY 1995 PPS Payment Impact File
- ¥ Memo to Vincent Roux from Robert Miller (University of California, San Francisco, Comments on "Proposed inpatient hospital fee schedule regulations"
- ¥ Memo from Marc Lowry, Califoria Assn. of Hospitals and Health Systems, dated 5/24/97, to Workers' Comp. Hospital Task Force on the subject of Agenda Material on Medicare DRG System
- ¥ Table 5: DRG
- ¥ 97 Composite
- ¥ Excerpts of the Federal Register/highlights of Table 5-Calculation of Prospective Paymetn Rates for FY 1996 (two copies)
- ¥ Excerpts of Health Care Financing Adm., HHS, ¤¤412.48-412.316
- ¥ Memo from Casey Young, dated 12/31/96, to ***Interested Parties Requesting Information on the Impatient Hospital Fee Schedule***
- ¥ Fax transmittals from Vincent Roux to Bob Miller, Ph.D. requesting his analysis of the cost factors; explanation of how DRG payment is calculated; and several tables of 1995 Cost Factors (effective 3/1/95)
- ¥ Declaration of Flordeliza Dizon in the Superior Court, Case No. 709283, Community Care Network, Inc. vs. Casey Young
- ¥ Declaration of Vincent Roux, with several attachs., in the Superior Court, Case No. 709283, Community Care Network, Inc. vs. Casey Young

#2 Hosp. Sked - Liza's files Apr. - June '97

- ¥ General Information on Medical Fee Schedules, Janet D. Jamieson, 03/11/92, with the following attachments:
  - * Responses to Written Comments re Inpatient Hospital Fee Schedule (8 pages of Q&A)
  - * Memo from Casey Young, dated 12/31/96, to ***Interested Parties Requesting Information on the Impatient Hospital Fee Schedule*** including adopted regulations, the health facility composite factors and the inpatient health facility DRG, outlier threshold, and length

of stay list

- ¥ Clipped pkg. of the following: DWC Newsline dated, 07/03/97, titled ***Inpatient Hospital Fee Schedule Delayed Pending Revision of Regulations*** (excerpts from the Labor Code included); copy of California Workers' Comp Advisor, Vol. 11, No. 6 covering *DWC wins first round in legal test of Inpatient Medical Fee Schedule*; excerpt from California Workers' Comp Advisor, p.6 (April 1997) . . . Young clarifies IMFS application and effect on contracts; DWC Newsline, dates 04/10/97, entitled ***Implementation of "Instructions For Payment Of Inpatient Hospital Bills" Delayed By Court***; Draft form(s) of SB 474 Workers' compansation, amended 04/17/97; one copy each of Flordeliza Dizon and Vincent Roux declarations
- ¥ Final print of the California Division of Workers' Compensation's
- ¥ Public Use Data Files
- ¥ E-note from Vincent Roux, dated 04/07/97, to Liza Dizon transmitting updated Public Use Data Files
- ¥ 97 Composite
- ¥ Variety of e-notes inter-office re hospital fee schedule
- ¥ Ltr. from Casey L. Young, dated 03/31/97, to Steve Johnson, CompReview, Inc., re the mailing list for DWC Newsline w/attached excerpt, p.6, Responses to Written Comments re Inpatient Hospital Fee Schedule; clipped, thereto, are several letters directed to Casey Young re clarification of the Inpatient Hospital Fee Schedule
- ¥ E-note from Linda Rudolph to Liza Dizon re the Hospital Fee Schedule with attached excerpts from the Office of Statewide Health Planning and Development/Patient Discharge Data Program Manual
- ¥ Ltr. to Vincent Roux, dated 04/26/97, from Cy King of Medata transmitting CA-DRG diskette and documentation

#3 <u>from: SCIF (Hosp. Fee Sked.) 4/97</u>

- ¥ Inpatient Fee Schedule (pink sheet)
  1.20 x Composite Factor x DRG Weight
- ¥ CA ID Numberic Order - Feb. 06 1997
- ¥ LAX ID Numberic Order - Feb. 06 1997
- ¥ Sheet 1 - Inpatient Fee Schedule Basic Fee Computation Examples
- ¥ Designated Trauma Centers (list of)
- ¥ Sample letter #1; sample letter #2 re inpatient billing
- ¥ DWC -- Listing of Health Facility Composite Factors
- ¥ Copies of sample bills (5)
- ¥ Memo from Casey Young, dated 12/31/96, to ***Interested Parties Requesting Information on the Impatient Hospital Fee Schedule***

including adopted regulations, the health facility composite factors and the inpatient health facility DRG, outlier threshold, and length of stay list; and a copy of the final print of the California Division of Workers' Compensation's **Instructions for Payment of Inpatient Hospital Bills**

- ¥ ARTICLE 5.7 as AMENDED (CCRs 9795.1 thru 9795.4) SUMMARY REASONABLE FEES FOR QUALIFIED INTERPRETERS* (yellow sheet)
- ¥ Article 5.7 Fees for Interpreter Services. (5 pages)
- ¥ Interpreters For Medical Treatment Services (guidelines)

Specific Technologies or Equipment

The proposed amendments would not mandate the use of specific technologies or equipment.

Alternatives to the Regulation Considered by the Agency

No alternatives to the amendments proposed have yet been identified or considered by the Administrative Director. It is the purpose of the present rulemaking process to solicit and consider alternatives.

Alternatives that Would Lessen Adverse Impact on Small Businesses

No alternatives to the amendment proposed have yet been identified or considered by the Administrative Director. It is the purpose of the present rulemaking process to solicit and consider alternatives.

PROPOSED CHANGES TO THE OFFICIAL MEDICAL FEE SCHEDULE TITLE 8, CALIFORNIA CODE OF REGULATIONS SECTIONS 9791.1 and 9792

Please note that the Official Medical Fee Schedule "establishes or fixes rates, prices, or tariffs" within the meaning of Government Code Section 11343(a)(1) and hence is not subject to Article 5 of the Administrative Procedure Act (commencing at Government Code Section 11346.) Rather, promulgation of the Official Medical Fee Schedule is under Labor Code Section 5307.1(a)(1). Nonetheless, the Administrative Director of the Division of Workers' Compensation gives this Initial Statement of Reasons in voluntary compliance with the Administrative Procedure Act.

General Statement of the Problem Addressed by Proposed Action

Labor Code Section 5307.1 requires the administrative director [AD] of the Division of Workers' Compensation [DWC] to "adopt and revise, no less frequently than biennially, an official medical fee schedule which shall establish reasonable maximum fees paid for medical services provided pursuant to [Division 4 of the Labor Code]." The Official Medical Fee Schedule [OMFS] was last revised in 1995.

General Statement of the Purpose and Basis of Proposed Action

The proposed amendments to the OMFS are to make the biennial revision required by Labor Code Section 5307.1. The proposals are based very largely on the work of the Official Medical Fee Schedule Task Force, a public advisory body convened by the Industrial Medical Council pursuant to Labor Code Section 139(e)(7) and the Administrative Director pursuant to Labor Code Section 5307.1(a)(3). In the introduction to its report to the Administrative Director, the Task Force explained its purpose and methods as follows:

This volume contains the recommendations of the Official Medical Fee Schedule Task Force (OMFS Task Force), a public advisory body convened by the Industrial Medical Council and the Division of Workers' Compensation to assist in the revision of the California workers' compensation official medical fee schedule. This Task Force was formed in parallel with a Task Force to revise the California workers' compensation medical-legal fee schedule. The recommendations of that Task Force are the subject of another volume.

Both Task Forces were convened pursuant to authority granted to the Industrial Medical Council and the Administrative Director by the Labor Code. Labor Code Sections 139(e)(7) and (8) direct members of the Industrial Medical Council within the scope of each members professional training: (a) to recommend reasonable levels of fees for physicians performing services under Division 4 of the Labor Code; and (b) in coordination with the Administrative Director, to monitor and measure changes in the cost and frequency of the most common medical services. Labor Code Sections 5307.1 and 5307.6 direct the Administrator Director of the Division of Workers' Compensation to adopt the official medical and medical-legal fee schedules no less frequently than biennially.

The OMFS Task Force met at least monthly between June, 1996 and February, 1997, in locations which alternated between northern and southern California. All meetings were publicly noticed and were open to any member of the workers' compensation community who wished to attend. Notice of the intent to hold meetings was sent to participants in previous DWC fee schedule advisory committees; to those on the IMC's mailing list and its lists of professional organizations; and to representatives of the payer and employer communities. The meetings were housed and supported by the Industrial Medical Council and were facilitated by Richard Sommer, Esq., a member of the Industrial Medical Council and chair of its Fee Schedule and Utilization Committee. Meetings were generally attended by approximately sixty individuals.

As its initial task, the OMFS Task Force developed the mission statement in Section 2 of this report. The Task Force identified and prioritized items for discussion at its meetings and set its own meeting schedule. Minutes taken at each meeting were disseminated to participants and to a larger "by request" mailing list. The Task Force was advised by the Administrative Director that all issues pertaining to the official medical fee schedule were "on the table".

Subcommittees were formed to review each of the sections of the OMFS and to report recommendations to the full committee for adoption or resolution. In addition to the section review subcommittees, an EOB (now EOR) Subcommittee was formed to develop the "Explanation of Review" messages found in Section 6. All subcommittee meetings were open to all who wished to attend.

The Task Force's procedure for identifying consensus evolved. Initially, the Task force chose to vote using a simple hand count (straw vote), believing it would be clear when consensus did not exist. Consensus votes in early meetings are therefore labeled "consensus" in the minutes. As the Task Force grew and the issues became more complex, the names of dissenting organizations and reasons for dissension were documented. In September, the Task Force adopted a two-tiered voting procedure, using an "A Vote/B Vote" plan to eliminate the potential bias which occurred when organizations had more than one representative in attendance. Each organization or entity was provided with a placard with the organization's name. For each item voted upon, an initial straw vote ("A Vote") was obtained. Any member of the Task Force could also call for a "B Vote" in which each organization/entity was entitled to only one vote (by placard). For "B votes", the names of all who voted (In Favor; Opposed; Abstaining) were recorded in the minutes. Consensus was recorded when two-thirds of the vote was affirmative. The votes on many issues reflected unanimity or near unanimity.

Task Force participants have collectively spent thousands of hours in preparation, meetings and discussions to resolve issues of concern. Many issues were resolved through this consensus driven process and are reflected in the draft of proposed changes to the OMFS in Section 3. Not unexpectedly, some issues remain unresolved. Payers and providers have recently been invited to submit position papers on many of these issues. Papers available at the time this volume was assembled appear in Section 5. In addition, the minutes of each meeting document the dialogue and concerns of stakeholders on each of the issues.

At its December meeting, the Task Force voted to adopt the AMA's 1997 version of its Current Procedural Terminology (CPT). Since the 1996 OMFS (© 1995) uses the 1994 CPT, adoption of the 1997 CPT has resulted in a three year update to CPT codes and ground rules. IMC staff has prepared a separate volume containing the 1996 OMFS (1994 CPT), updated with the 1997 CPT.

The Administrative Director has followed almost all the recommen-dations of the Task Force. In certain limited areas, the Administrative Director has not followed the Task Force's recommendation, but makes his own proposals for amendment.

Particular Problems Addressed by the Proposed Action Together with the Purpose and Basis of Each Proposed Action

(1)(a) Problem: The Official Medical Fee Schedule is Not Properly Incorporated by Reference in the Code of Regulations

The Official Medical Fee Schedule is a document that runs in excess of 300 closely printed, double-columned pages. It is not feasible to publish such a document in the Code of Regulations. It is necessary to publish it separately, but give it the legal effect of a regulation by incorporating it by reference. Incorporation by reference requires very particular language in the regulations, as laid out by the Office of Administrative Law in Title 1, Cal. Code of Regs. Section 20{c}(4).

However, the present version of 8 Cal. Code Regs. Section 9791.1, which promulgates the OMFS, does not have the necessary language.

(1)(b) Purpose and Basis of the Proposed Action: Amend Section 9791.1 to Incorporate the OMFS by Reference

It is proposed to amend Section 9791.1 to contain the language required by the Office of Administrative Law. This is a small technical amendment with no substantive impact.

(2)(a) Problem: Out-of-Date CPT Codes

The OMFS lists many specific medical procedures and assigns a relative value [RV] for each. (When an RV is multiplied by the appropriate "conversion factor" found in 8 Cal. Code Regs. Section 9792, the reasonable maximum fee is determined.) In the 1995 edition of the OMFS, the medical procedures were defined and numbered according to the 1994 *Physicians' Current Procedural Terminology*, published by the American Medical Association [AMA]. These are commonly called CPT codes. For instance, removal of pancreatic calculus has the CPT Code 48020. The 1994 CPT Codes no longer adequately reflect current medical practice. With the advance of medical science, these procedures change over time, some dropping out altogether, and some new procedures coming into use.

Along with these CPT codes, the AMA publishes "modifiers" -- numerical suffixes that may be attached to CPT codes. As stated in the OMFS, "A modifier provides the means by which the reporting physician or health care provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." Modifiers are means of communication between physicians and payers. Usually they do not require an automatic change in the level of reimbursement. These modifiers sometimes need to be changed to reflect modern medical practice.

(2)(b) Purpose and Basis of the Proposed Action: Update CPT Codes and Modifiers in Accordance with 1997 AMA Codes

The proposed OMFS reflects all additions, deletions and revisions from the 1994 CPT Codes to the 1997 CPT Codes. The 1997 Codes are based on the publication *Physicians' Current Procedural Terminology CPT '97*, published and copyrighted in 1996 by the American Medical Association. A copy of that publication will be made available at the public hearings and will be a part of the administrative record for this amendment to the OMFS. CPT Codes are published in this OMFS by permission of the AMA. The OMFS Task Force found the AMA's 1997 CPT revisions to be an accurate reflection of current medical practice, and therefore recommended their adoption.

The present proposal would change a small number of CPT codes as published by the AMA and would add a number of new codes and modifiers that are unique to California. When this has been done, the change or addition is indicated by the symbol: ∞ .

Some of the California changes and additions are merely for clarification. Others have a minor effect. This Initial Statement of Reasons will discuss those new and changed codes and modifiers that appear to have a significant impact on payments.

3(a) Problem: Out-of-Date Relative Values

The reasonable maximum fee that a medical provider may charge a payer is determined by multiplying a conversion factor (set at 8 Cal. Code Regs. Section 9792) by a "relative value" figure [RV] for each medical procedure. Most CPT codes have an RV figure associated with it. For instance, removal of pancreatic calculus (CPT Code 48020) has a relative value of 6.4. With the publication of new or revised CPT codes, there must be an RV figure for each new or revised CPT code. Also, there are some CPT codes in the current OMFS that do not have a relative value figure. In those instances, the medical provider bills "By Report" [BR]. The current proposal will give RV figures for some of the codes that were previously BR.

3(b) Purpose and Basis of Proposed Action: Update Relative Values

The proposed OMFS retains the RV values from the last edition of the OMFS for most of the old CPT codes. The proposed OMFS gives new RV figures for new CPT codes. In some instances it gives new RV figures for revised CPT codes, particularly where old CPT codes were "unbundled" to give a more detailed description of the medical procedures involved. A particularly noteworthy example is the revaluing of CPT codes 22842 and 22845, which concern surgical procedures on the spine. The proposed OMFS gives new, more detailed codes for those procedures and greatly reduces the RVs.

The new and updated RV figures are based on proprietary materials prepared by Medicode, Inc. In particular, Medicode delivered to the IMC in July 1996 a document entitled *IMC Contract Deliverables 1 and 2*, which contains a complete list of RV values, calibrated to the California OMFS. A copy of that publication will be a part of the administrative record for this amendment to the OMFS.

Medicode describes its basic methodology as follows:

> In assigning relative values, Medicode's relative value committee compares the code with functionally similar codes according to the technology, resources, required skills, intensity, and time of the procedures. Technical descriptions of the procedures are obtained from physician associations as needed. Inquiries may be made to the AMA for further

clarification of the intent and use of the code. To assign a relative value the committee evaluates all available information and uses clinical judgment to assess the work, required skill, intensity, time and other factors involved in performing the procedure.

(Medicode, *Deliverable #2*, page 5.)

In some instances, the proposed OMFS gives RVs that are different from those given by Medicode. This Initial Statement of Reasons will discuss those differences that appear to be significant.

4(a) Problem: Out-of-Date Conversion Factor for Evaluation and Management Services

As noted above, the reasonable maximum fee that a medical provider may charge a payer is determined by multiplying a "relative value" figure [RV] for each medical procedure by a "conversion factor," as set forth at 8 Cal. Code Regs. Section 9792. For instance, the conversion factor for the radiology section is $12.50. For the radiological procedure of needle biopsy of intrathoracic lesion (CPT 71036), the RV is 10.1. A physician performing that procedure could charge a maximum of 10.1 x $12.50 = $126.25.

One conversion factor is for “Evaluation and Management Services,” which covers physician services -- such as taking a history from the patient, examining the patient, reviewing other medical records, consulting with other physicians, etc. – which are distinct from direct treatment, such as giving an injection or performing an operation. These evaluation and management services are of exceptional importance in workers’ compensation. The treating physician in workers' compensation must prepare reports on the treatment plan, disability status, vocational rehabilitation status, and must perform an initial disability evaluation. Additionally, the workers' compensation treating physician must manage the injured worker's return to work, and may engage in communications with the insurer and employer which are not typically required in treating the non-workers' compensation patient. These additional services virtually all fall within the domain of evaluation and management codes. Many of these services were required by the 1993 workers' compensation reforms, which placed additional requirements on the primary treating physician (see, e.g., Labor Code Section 4061.5.)

5(b) Purpose and Basis of Proposed Action: Increase Conversion Factor for Evaluation and Management Services.

It is proposed to increase the conversion factor for evaluation and management services from $7.15 to $8.50. This increase is intended to compensate physicians for the increased knowledge and skill required to evaluate and manage workers' compensation patients. The figure of $8.50 was chosen to bring

reimbursement levels for evaluation and management services closer to equivalent reimbursement levels set by the federal Office of Workers' Compensation Programs.

(6)(a) Problem: The Effect of the Fee Schedule on Contracts

Over the years there has been considerable uncertainty on the effect of the Official Medical Fee Schedule on contracts between medical providers and payers.

On the one hand, Labor Code Section 5304 states that the Workers' Compensation Appeal Board has jurisdiction over disputes for medical payment "*unless an express agreement fixing the amounts to be paid"* has been made between the provider and the employer or insurer. If there is such an express agreement, then jurisdiction is with the municipal or superior court of the county. This suggests that the parties may set whatever prices they please. An official fee schedule is needed only when there is no agreement between the parties -- for instance, when the employer is obliged to pay a physician selected by the injured worker.

On the other hand, Labor Code Section 4614(c) implies that "alternative negotiated rates" between providers and payers must be approved by the Administrative Director if they differ from the official fee schedule. The reach and significance of Section 4614 are very uncertain. It is not clear which sorts of contracts are affected by Section 4614.

Aside from the legal ambiguity, there is a policy question: What purpose is served by the Administrative Director setting fees that are different from those negotiated by the parties? What advantage is there, if any, in impeding market forces?

(6)(b) Purpose and Basis of Proposed Action: Exclude Contracts from the OMFS

In the OMFS General Information section, it is proposed to add after the first paragraph of "Services Covered":

> The Official Medical Fee Schedule does not apply when there is an express written agreement, made between the persons or institutions rendering such treatment and the employer or insurer or an agent thereof, which fixes the amounts to be paid for medical services.

As to the ambiguous legal question of his authority to set maximum fees that could override privately negotiated fees, the Administrative Director's opinion is that he might have such authority. The Administrative Director *could*, in his opinion, promulgate an official medical fee schedule that would set maximum fees for all medical services rendered to injured workers, whether the services were

provided under contract or not. (If the official medical fee schedule were applied to contracts, then Section 4614(c) would provide parties with an exemption in certain circumstances.) But the Administrative Director is not required to stretch his authority to the maximum. In the past, for instance, hospital stays were not covered by the fee schedule. There are still many individual services for which the fee schedule does not set an exact dollar figure (e.g., CPT codes whose relative values are not specified but are listed as "by report.") In other words, the Administrative Director has authority to promulgate a fee schedule that does not cover every situation that in theory might be covered.

Therefore, the Administrative Director proposes that the OMFS cover only those services for which there is no contract between the medical provider and the claims administrator or their agents. If there is a contract between the parties that is enforceable in county courts, rather than the WCAB, the OMFS will not apply. In the Administrative Director's opinion, it is better to avoid regulation in an area where the parties have made their own agreements.

Note that this proposal would allow contracts that set rates either above or below the OMFS, or based on completely different methods of payment, such as capitated rates.

7(a) Problem: Use of Evaluation and Management Codes by Non-Physicians

There has been some confusion in the past concerning the use of E/M codes by non-physicians, such as nurse practitioners, physicians' assistants, and physical therapists.

7(b) Purpose and Basis of Proposed Action: Clarify Rules Concerning Use of E/M Codes by Non-Physicians

It is proposed to state explicitly that E/M codes may be used by nurse practitioners and physicians' assistants working under a physician's direction. In that situation, a modifier [-*98*] must be used. The modifier is intended as a convenient method of communication between provider and payer in the situation. It is also proposed to state explicitly that physical therapists may use only those evaluation codes designed for them (CPT 98770 - 98778) and not codes in the E/M section.

8(a) Problem: Distinguishing Between Osteopathic and Chiropractic Manipulation Codes

A significant change resulting from the up-dating of CPT codes is the introduction of specific codes for chiropractic manipulation. The current OMFS has a variety of manipulation codes, including generic manipulation codes, used by all provider types, including chiropractors. The addition of specific chiropractic manipulation codes by the AMA was at the request of the chiropractic professional

organizations. There has been some concern raised during the OMFS Task Force discussions that, because higher reimbursement may derive from the use of non-chiropractic manipulation codes, chiropractors may change billing practices to maximize reimbursement by avoiding the use of chiropractic manipulation codes.

8(b) Purpose and Basis of Proposed Action: Limit Use of Osteopathic Manipulation Codes to Licensed D.O.s and M.D.s.

The proposed OMFS specifies that only D.O.s and M.D.s may use the osteopathic manipulation codes. Chiropractors will use codes chiropractic codes. Generic manipulation codes (CPT 97260 and 97261) are eliminated.

9(a) Problem: Unspecified Reimbursement Levels for Supplies and Materials

The current OMFS states that supplies and materials "necessary to perform [a particular] service are not separately reimbursable. Those supplies and materials that are "over and above those usually included. . . may be charged for separately." This separate charge is "by report" -- that is, the OMFS does not specify the reimbursement. Providers and payers both need greater certainty in this area.

9(b) Purpose and Basis of Proposed Action: Specify Reimbursement Levels for Supplies and Materials.

The proposed OMFS gives specific examples of common supplies and materials that are "normally necessary" and hence not separately reimbursable. It also gives examples of common supplies and materials that are separately reimbursable.

In addition, it gives a specific formula for setting reimbursement rates under CPT 99070, based on the actual cost of supplies and a small mark-up.

This section of the General Instructions was the subject of prolonged and repeated meetings of the Supplies and Materials Work Group, a subcommittee of the OMFS Task Force. The listing of reimbursable and non-reimbursable items should bring certainty to an area marked by much confusion and dispute. The very modest mark-up for supplies and materials (normally 20% of cost, up to a maximum of cost plus 15%) recognizes the costs to the physician of maintaining an inventory of supplies and dispensing them -- but gives no financial incentive to dispense them needlessly.

10(a) Problem: Many Required Medical Reports are Not Reimbursed

In the workers' compensation system, treating physicians may be required to make numerous reports to the payer[1] :

+ The Doctor's First Report of Occupational Illness or Injury (Labor Code Section 6409) and / or an initial examination report (8 Cal. Code Regs. Section 9785(b))

+ Periodic progress reports that are triggered either by the passage of time (45 days), or by 12 office visits (9785(c)).

+ Event triggered reports -- e.g., upon a significant change in the patient's condition, or a request for information by the employer) (Section 9785(d))

+ Reports requested by the payer (Section 9785(d)(7))

+ Disability status reports (Section 10124)

+ "Permanent and Stationary" reports (9785(e))

+ "Consultation" reports

Under the present OMFS, most of these reports are *not* separately reimbursable. The exceptions are "permanent and stationary reports," "consultation" reports, "disability reports" where the physician is able to render an opinion, and reports requested by the payer that are more than "brief." However, physicians expend considerable time and expense in preparing reports -- such as periodic progress reports -- that are not paid for now.

10(b) Purpose and Basis of Proposed Action: Make Almost All Reports Reimbursable

All the reports listed above would be reimbursable, except the initial report and disability status reports where the physician is unable to render an opinion. The initial reports would still not be separately reimbursable since their value is already included in reimbursement for the initial office visit. Furthermore, these initial reports are very similar to the sort of notes and / or reports that a physician in any setting would make -- e.g., name of patient, date of injury, diagnosis, etc.

Other reports, however, are unique to the workers' compensation system -- e.g., 45-day progress reports -- and are not necessarily tied to any particular office

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[1] It should be noted that, concurrently with this proposed revision to Administrative Director is proposing to amend Sections 9785 and 9785.5 of Regulations. The proposal would consolidate the two sections and w different numbering system for identifying reports. In this Initial S Reasons, however, we refer to those section numbers currently in effec

visit. Nonetheless, these reports take time for a physician to prepare and are of value to the payer. These reports should be reimbursed (a) as a matter of fairness to the physician, and (b) in order to enhance the quality of the reports.

11(a) Problem: Need to Adjust Prolonged Service codes

Because of the extraordinary importance of evaluation and management in the workers' compensation setting, including further duties imposed on the physician by the 1993 reforms, it is common for physicians to spend extra time reviewing records, tests, job analyses, etc. The CPT code for this extra time is 99358. The current code includes only review of records and tests and makes no mention of the special evaluation and management services performed in the workers' compensation system. Also , the current CPT allows for billing of prolonged service in a one-hour block with an RV of 17.9, followed by 30-minute blocks with an RV of 9.0.

11(b) Purpose and Basis of Proposed Action: Amend CPT 99358 to Include Workers' Compensation Services and Reduce Time Blocks to 15 Minutes

It is proposed to include within CPT 99358 those services that are common in workers' compensation, such as job analysis, evaluation of ergonomic status, etc.

At the same time, it is proposed to break down the time blocks for prolonged service from 1 hour + 30-minute increments to 15-minute increments, with an appropriate reduction of the RV. Instead of an RV of 17.9 for one hour, there will be an RV of 4.5 for 15 minutes. This should give both providers and payers a more accurate basis for reimbursement.

12(a) Problem: Reimbursement for Reproduction of Chart Notes, X-rays and Duplicate Reports

Payers commonly request physicians to provide copies of their charts, X-rays, scans and/or to provide duplicates of reports already made. These items are not separately reimbursable in the present OMFS. The physician must bear the cost of these items, though they are solely for the benefit of the payer.

12(b) Purpose and Basis of Proposed Action: Reimburse for Reproduction of Chart Notes, X-rays and Duplicate Reports

The proposed OMFS makes chart notes and duplicate reimbursable at the rate of $10 for the first 15 pages and $0.25 per page thereafter. Two new codes are created for billing purposes: 99086 for chart notes and 99087 for duplication of reports. Reproduction of X-rays and scans will be reimbursable "by report." New codes will be 76175 and 76176,

This recognizes the fact that reproduction of chart notes, X-rays and reports costs the physician money and is solely for the benefit of the payer. It is appropriate that the payer bear the cost.

13(a) Problem: The Present OMFS Does Not Have a Code for Physicians to Indicate Missed Appointments

When a patient makes an appointment, the physician sets aside time for see the patient. When the patient fails to keep the appointment, the physician may or may not be entitled to some reimbursement. At present these is no code to indicate a bill submitted to the payer in this situation.

13(b) Proposed Action: Provide a Code for Missed Appointments

The proposed OMFS includes a new code -- 99045 -- for missed appointments. No RV is given since, by definition, no medical procedures have been performed. The physician therefore will charge "By Report." Any reimbursement will be determined by the parties. The code is designed solely as a convenient method of communication between provider and payer.

14(a) Problem: Lack of Reimbursement for Use of Interpreter

It happens commonly that a physician must evaluate and treat an injured worker who has no common language with the physician. For actual treatment of the patient, such as performance of a surgical procedure, this lack of communication does not usually impose any extra burden on the physician. But for evaluation and management of the patient, communication is vital. Not only must the physician learn of the patient's complaints and history, the physician must also discuss the patient's work, disabilities, limitations, and other matters unique to the workers' compensation system. When an interpreter is used to communicate (regardless of who supplies the interpreter) the examination takes more time. Physicians should be reimbursed for this time.

14(b) Purpose and Basis of Proposed Solution: Create Modifier -93 Which Would Multiply Evaluation and Management RVs by 1.1

It is proposed to increase evaluation and management RVs by 10% when an interpreter is required.

15(a) Problem: Reimbursement for Treatment of Psychological Injuries by Physicians and Non-Physicians

The Psychiatric Advisory Committee of the Industrial Medical Council brought to the attention of the OMFS Task Force two inter-related problems: first, that the reimbursement levels for psychiatric treatment of injured workers as recommended by Medicode are substantially below the prevailing reimbursement

values for psychiatrists and doctoral-level clinical psychologists; and second, that this problem most likely derives from the fact that Medicode data did not differentiate between services provided by physicians (as defined by L.C. 3209) and non-physicians (e.g. marriage and family counselors or clinical social workers). Outside of the workers' compensation system, the reimbursement to these different categories of providers is differentiated.

15(b) Purpose and Basis of Proposed Action: Reimburse Non-physicians Who Are Not Acting Under the Direct Supervision of a Physician at a Lower Rate, Through Use of a Modifier.

The proposed OMFS introduces a modifier [-97] for use by non-physicians giving psychological treatment who are not acting under the direct supervision of a physician. The modifier would have the effect of multiplying the RV by 0.6. The proposed OMFS also raises the RV for certain psychiatric treatment codes, so that reimbursement for psychiatric treatment of workers' compensation patients is more comparable to that in other systems. The purpose of these proposed changes is to ensure continued access of workers' compensation patients to qualified professionals for psychiatric treatment, and to make the workers' compensation reimbursement consistent with other payers with regard to the differential between two categories of providers. The increase of RVs to physicians was set by comparison to reimbursement levels used by the federal Office of Workers' Compensation Programs.

16(a) Problem: Inflexible Limits on Reimbursement for Physical Medicine

The current OMFS limits reimbursement for chiropractic and other physical medicine services to a daily maximum of two physical therapy procedures and two modalities. The AHCPR "Guidelines for the Treatment of Low Back Injuries" suggests that passive modalities may not be as effective as more active procedures. The present reimbursement structure may encourage the use of less effective treatment methods.

16(b) Purpose and Basis of Proposed Action: Allow Greater Flexibility for Use of Any Four Treatment Methods

It is proposed to maintain the limit of four treatment units per day, but not to specify what sort of treatments those are. This would allow the health care provider more flexibility in choosing the most effective regimen for the patient.

(At the same time, it is proposed to strike the extraordinarily confusing Ground Rule 1g from the Physical Medicine and Rehabilitation section, which dealt with physical therapy evaluation codes.)

17(a) Problem: Treaters Were Being Paid to Apply Hot and Cold Packs

A common form of physical medicine is the application of hot or cold packs to an affected area. However, such an application requires no medical training, skill or equipment of any sort.

17(b) Purpose and Basis of Proposed Action: Eliminate Payment to Treaters for this Service

The proposed OMFS lists an RV value of 0 (zero) for CPT 97010. In this we follow the example of Medicare, which likewise does not reimburse for this service.

Documents Relied Upon

1. *Recommendation of Task Force on Official Medical Fee Schedule (March 1997)* , including numerous sub-committee reports and communications contained therein.

2. *Physicians' Current Procedural Terminology CPT '97*, published and copyrighted in 1996 by the American Medical Association.

3. *IMC Contract Deliverables 1 and 2, and 5 and 6,* created by Medicode, Inc.

4. Memorandum from Glenn Shor to Casey Young, *Medical Costs Baseline for OMFS Fiscal Impact* (September 15, 1997).

5. Workers' Compensation Insurance Rating Bureau, *Cost Impact of 1994 Official Medical Fee Schedule*, January 11, 1994.

6. Workers' Compensation Insurance Rating Bureau, *Filing to Insurance Commissioner proposing Pure Premium Rate adjustments effective 1/1/98.* Filed with DOI on August 6, 1997, File RH 363

7. Workers' Compensation Insurance Rating Bureau, *1989 Reform Act - Cost Monitoring Report per Insurance Code section 11751.51* (February 6, 1997)

8. Workers' Compensation Insurance Rating Bureau, *Bureau Annual Report summarizing aggregate calendar year costs, per Insurance Code section 11759.1* (May 30, 1997)

9. Workers' Compensation Insurance Rating Bureau, *1996 California Workers' Compensation Losses and Expenses* (June 1997)

10. Workers' Compensation Insurance Rating Bureau, *WCIRB Bulletin, Policy Year Statistics* (April 3, 1997)

11. California Workers' Compensation Institute, *Direct Expenses of Litigation, Bulletin 93-8* (May 14, 1993)

12. California Workers' Compensation Institute, *Research Abstract: Medical Billing Under the California Official Medical Fee Schedule*, August 1997

13. California Workers' Compensation Institute, *Research Abstract: OMFS Cost Drivers*, forthcoming

14. State of California, Department of Industrial Relations, Division of Workers' Compensation, *Official Medical Fee Schedule, 1996*

15. State of California, Department of Industrial Relations, Office of Self-Insurance Plans, *Internal data on Payroll of self-insured employers.*

16. U.S. Department of Labor, Office of Workers' Compensation Programs, *OWCP Medical Fee Schedule, 1997* (March 1, 1997)

17. American Medical Association, *CPT Guide*

18. Medicode, *Report to Industrial Medical Council on proposed changes to Official Medical Fee Schedule*, November 1996.

19. Minutes of OMFS/MLFS Task Forces Committee Meeting, March 19, 1997.

20. CWCI, Research Abstract, *Medical Billing under the California Official Medical Fee Schedule*, August 1977

The following documents are maintained in folders numbered and labeled as follows:

#1 <u>OMFS</u>

- WCIR Research Brief, April 1996 re Medical Fee Schedule
- E-mail note from Jackie Schauer to Linda Rudolph
- Ltr. from Casey Young dated 5/29/96 to the Workers' Comp. Committee re upcoming mtg. on OMFS & Med.-Legal Fee Schedule
- Memo dated 6/12/96 from Resemary Payne to Linda Rudolph re issues on Fee Schedule
- Minutes of Fee Schedule Committee Mtg. dated 4/18/96 held at the S.F. Hyatt/Embarcadero - Richard Sommer, Esq., Chair
- IMC Deliverable #6 -- Conversion Factors (2 copies)
- California Workers' Compensation Medical Fee Schedule -- Prudent Buyer Comparison REGION VIII
- Outline of Developing the Schedule
- Prudent Buyer Comparison SUMMARY
- CWCI (newsletter) Research Update - Medical Care
- Ltr. from Casey Young to Dr. Bronshvag in response to the

doctor's request of 12/17/93 (no copy of that ltr. in file)

#2 OMFS Advisory

- Notice of Public Mtg. w/Attached Minutes of Fee Schedule Advisory Committee Mtg. of June 13, 1997
- BUNDLE includes: Summary of OMFS Advisory Committee Mtg. dated 6/27/96; Attendees; Minutes of mtg. held 6/13/96; ltr. from Exec. Dir. Matt Weyuker of OPSC to Dr. MacKenzie, dated 6/26/96 re the publication of MFS; ltr. from Doug Brenner (CMA) dated 6/18/96 to Casey Young re continuous update of OMFS; memo dated 6/18/96 from Henry Ludlow, M.D. (CMA) to Dr. MacKenzie re OMFS ground rules (2 copies); memo from Sharon Barrilleaux to Dr. MacKenzie dated 6/20/96 re OMFS ground rules (2 copies); ltr. from Maklies Theissen (Nat'l Product Consultant) to IMC re Comments on Potential Revisions to OMFS & Med.-Legal Fee Schedule; ltr. from I&A officer Luisa Martinez to Dr. MacKenzie dated 6/20/96 re general questions she routinely receives re OMFS; ltr from Rea Crane, Med/Rehab. Director (CWCI) to Legal Counsel, Suzanne Maria, IMC, re grounds to revise in OMFS; several ltrs. to Rosemary Payne from many different medical entities re area of concerns (medical procedures) needing clarification dated Jan.-Apr. 1996; several ltrs. sent (faxed) to Legal Counsel Suzette Marria from Deborah Alves, Branch Mgr. of GENEX SERVICES, INC. on 6/12/96 re ground rules, Med.-Legal concerns and specific procedure codes; ltr. from BEECH STREET attaching comments re discrepancies with billing codes; Notice of Public Hrg., 6/27/96, OMFS Advisory Mtg., Facilitation of Fee Schedule Mtgs (2 copies); ltr. dated 6/18/96 from Beech Street to Dr. MacKenzie forwarding previous coments sent to Rosemary Payne with additions; ltr. from William Newmeyer, III, dated 6/26/96 to IMC re the pressures placed on physicians who treat workers' compensation patients; memo dated 6/24/96 from Bill Hutchins of APTA to Casey Young re concerns with Ground Rules
- Minutes of OMFS Advisory Committee Mtg. held 12/13/96
- OMFS Advisory Committee List dated 10/22/95

#3 OMFS/Advisory

- Fax to Susan McKenzie, IMC, from BEECH STREET of CODES, MODIFIERS and SYMBOLS, etc.
- Minutes of the OMFS Advisory Committee Mtg. held 2/20&21/97

at the Holiday Inn, LAX
- Agenda - OMFS/MLFS Task Force Mtg., Hyatt Regency, SFO 3/19/97
- Correction Notice from Susan McKenzie, M.D. re Minutes of the OMFS Advisory Committee Mtg., dated 3/24/97
- Minutes of OMFS/MLFS Task Forces Committee Mtr. 03/19/97

#4 <u>OMFS/Adv. Committee</u>

- Minutes of the OMFS Advis. Comte., 9/26/96 (2 copies)
- Minutes of IMC Fee Schedule and Utilization Comte. Mtg. 9/19/96
- Notice of Public Meetings (last revised 8/8/96) 2 copies
- Summary of MLFS Advis. Comte. Mtg., 8/15/96
- Summary of the OMFS Advis. Comte. Mtg., 7/25/96
- OMFS Advis. Comte. Mtg., 10/17/96
- Memo from Rosemary Payne to Linda Rudolph, dated 8/19/96 re mtg. held 8/14/96 re OMFS
- Memo from Rosemary Payne to Linda Rudolph, dated 8/19/96 re mtg. held 7/25/96 re IMC/OMFS Advisory Committee
- Minutes of OMFS Advisory Committee Mtg. held 11/7/96
- Minutes of the OMFS Advisory Committee Mtg. held 2/20&21/97 at the Holiday Inn, LAX
- Minutes of the OMFS Advisory Committee Mtg. held 1/16/97 at the Grosvenor Hotel, LAX

#5 <u>OMFS/Advisory/IMC</u>

- List of Motions at Mtg. (no date)

#6 <u>OMFS/Anesthesia</u>

- Codes 00100 thru 01999 [1996 written in corner]
- Codes 0100-01999 [1994 written in corner]
- E-note from Liza Dizon to Linda Rudolph dated 7/2/97 indicating comparison of the two above.
- Typed page of comments re ANESTHESIA (from 1997 Physician Fee Sched. Final Rule) Federal Register - 22 Nov. 1996
- Two computer printouts of Final Rule
  1 - hand-written Fed. Register Dec. 1994 2 - hand-written Fed. Register Dec. 1995

#7 <u>OMFS/Appendix</u>

- APPENDIX B Memo from Suzanne Marria to Susan McKenzie, M.D. recommending L.C. sections and regs. be included in Appendix B of revised OMFS

#8 OMFS/CCA

- A Proposal w/Rationale for New Chiropractic Manipulative Treatment, 1997 OMFS dated 7/16/97 from the CCA

#9 OMFS/C Med. Ass.

- Ltr. to Casey Young, dated 11/8/96, from CMA re OMFS Conversion Factors
- Agenda for Mtg btwn DWC and CMA held 3/11/97 (notes taken by Casey re comments made and by whom)

#10 OMFS/Complaints

- Ltrs. from Linda Rudolph, M.D., dated 2/10/97, to the following persons in response to their complaints regarding the manner in which medical billing and/or reimbursement by the w/c payor:
  * Marc Francis of JONES, CLIFFORD, MCDEVITT, et al.
  * Dr. Larry A. Koeneke, PAIN RELIEF
  * Dr. Robert J. Casanas, Phys. Med. & Pain Mgmt.
  * Cheryl R. Andrews, Cheeley Chiropractic, Inc.

  (attached to this one are 17 complaint forms from various ins. carriers and review companies)
- Same ltr. above, dated 2/3/97, to the following persons:
  * Sherry Cannon, Plastic & Reconstructive Surgery
  * Dr. Robert Marx
  * Rebecca Hein, Office Mgr. for Dr. Richard Nolan
- Ltr. from Casey Young, dated July 29, 1996, to Dr. Phillip Wagner of HOEM Humboldt in response to his ltr. of June 26, 1996 concerning SCIF's reimbursement policy. (Dr. Wagner's complaint ltr. is not in file.)

#11 OMFS/Complaints

- Physician's Downcoding Complaint Form by Dr. Edward Stokel rec'd 11/21/96.
- CC of a ltr. dated 1/7/97 from The Bloch Medical Clinic to F.I.R.M. Solutions notifying an outstanding balance. Offer to settle lien.
- Physician's Downcoding Complaint Form from Dr. Torsten Jacobsen rec'd 4/29/97
- Medical Billing/Reimbursement Complaint Form from Royal Insurance Company rec'd 4/22/97

#12 OMFS/Complaint/Legal

- Ltr. from Tom Cresswell of Cresswell Physical Therapy, dated 4/15/97, to Dr. Linda Rudolph forwarding a complaint ltr. he wrote to Kemper Nat'l. Services re interpreting Ground rule 1g.

#13 OMFS/Conversion Factors

- Ltr. dated 3/13/97, from Dr. Linda Rudolph to Dr. Alan Hunstock, in response to his ltr. of 2/24/97regarding reimbursement rates for physicians in California workers' compensation system.
- Ltr. from Dr. Henry Lubow of Advantage Care Medical Grp., dated 11/3/96, briefing Casey Young on the 10/17/96 meeting of the IMC Fee Schedule Sub-Committee.

#14 OMFS/Conversion Factor/Provider Comments

- an excerpt from Calif. Workers' Comp. Advisor (pg. 11-12) covering the E/M service . . . compensated at higher rate . . .
- A form ltr. from Dr. Rudolph re reimbursement rates for physicians (however, no final form dated) with attached ltrs. of complaint from the following:
    * David L. Chittenden, M.D.
    * Henri A. Cuddihy, M.D. of Foothill Med. Ctr.
    * Barbara J. Julier, M.D.
    * Gabriel M. Kind, M.D.
    * Irwin I. Rosenfeld, M.D.
    * Alfred N. Roven, M.D.

#15 OMFS/Correspondence

- CC of a ltr. from Peggy Jones to Dr. David Scharf, dated July 24, 1996, regard H or F reflex study.

#16 OMFS/cost analysis

- Minutes of 4/7/97 Mtr. of the Director's Office on the Fiscal Analysis w/Initial Rulemaking
- CC of a ltr. from Lisa Middleton, SCIF Claims Mgr., to Casey Young, dated 4/14/97, re Data to Support ConversionFactor Changes
- Memo to Group Health Providers from Rea Crane, CWCI, dated 3/31/97 re Medicode Data w/attachment of a memo from Casey Young to Interested Parties re Information relevant to revision of the Official Medical Fee Schedule.
- Faxed copy of Proposal for Evaluating the OMFS from J. Jamieson,

dated March 4, 1997

#17 OMFS/CWCI

- Executive Briefing - June 05, 1997 from webmaster.cwci@inlet.com.
- CWCI Bulletin dated July 16, 1997
- Comment sent back to Ed (CWCI) re Executive Briefing by Casey Young, dated 7/9/97
- Ltr. from Casey Young to President of CWCI, in response to Mr. Woodward's ltr outlining some of the concerns regarding process at the IMC-chaired OMFS advisory committee mtgs. (Mr. Woodward's ltr. is not in file.)
- Listing of proposed changes by section in the OMFS Fiscal Impact of 1997 Proposed Changes to OMFS & MLFS

#18 OMFS/Data

- Memo from Casey Young, dated 3/5/97, to Interested Parties re Information relevant to revisions of the OMFS; noted mailed out 3/10/97

#19 OMFS/disability evaluation

- Memo dated 11/5/96 from Luisa Martinez to all I&A officers statewide re Treating physicians billing for Medical-Legal Fees

#20 OMFS/downcoding

- Ltr. from Douglas Benner, M.D. of California Medical Assn., to Casey Young, dated July 8, 1996, re downcoding problem
- Table 1 - Frequency of Provider Submitted Complaints about Insurance Carriers Sorted by Insurance Carriers - 1995
- Memo to Workers' Compensation Medical Providers & Claims Administrator from Casey Young, dated 6/5/95, re Disputes over Billing and Reimbursement for Medical and Medical-Legal Services
- Ltr. from Robert W. Ehle, Jr., Claims Mgr. of SCIF to Dr. Jagdish Patel, M.D., dated 11/26/96, re alleged'down coded' bills.
- Copy of a ltr. from IMC to Hector Martinez, Hrg. Rep. for Dr. Alex Latteri, referring his complaint re alleged improper change of billing codes to the Administrative Director.

#21 OMFS/E&M

- Executive Briefing - July 15, 1997 webmaster.cwci.@inlet.com.

#22 OMFS/HCFA

- computer printout of Final Rule titled TABLE OF CONTENTS/ACRONYMS/SUMMARY/LEGISLATIVE HISTORY, etc. 42 CFR Parts 410 and 415

#23 OMFS/IMC

- Ltr. to Casey Young w/CC to Linda Rudolph from Dr. MacKenzie, dated May 6, 1997, re reconvening a meeting to discuss unresolved and controversial issues which resulted from the fee schedule development process.
- Ltr. to Edward Woodward, CWCI, dated May 29, 1997, from Richard Sommer, IMC, in response to the recent ltr. rec'd from Rea Crane which she criticized statements Mr. Sommer made on the proposed cost impact study at the 4/17/97 mtg.
- DRAFT of Interagency Agreement Btwn the IMC and DWC
- Memo from Luisa Martinez, I&A Officer to Bob Wong, Mgr. dated 10/28/96, re mtr. held btwn IMC and DWC on 10/24/96 - A&Q session.

#24 OMFS/Inquiries

- Faxed memo from Gayle Walsh, D.C, IMC, to Casey Young, A.D., DWC, dated 9/12/96, re OMFS sub-committee mtg. held 9/11/97 and requesting info. re Osteopathic codes to be discussed at 9/26/96 upcoming mtg.
- Ltr. from Bill Hutchins of APTA, dated 8/22/96, thanking Dr. Rudolph for bringing the CCAPTA into the current discussion of OMFS Physical Medicine Groud Rule 1g. Discusses primary issue and propose language.

#25 OMFS/Legal

- Memo from Linda Rudolph to Susan McKenzie, dated 12/10/96, on the subject of groundrule 1(g) cc: Jackie Schauer
- Faxed copy of a ltr. to Linda Rudolph, dated 12/16/96, from Bill Hutchins of APTA re how some codes in the Official Medical Fee Schedule were developed and what is embedded within the value of the codes.
- Memo to Linda Rudolph, MD, dated 2/6/96, from Vincent Roux and Luisa Martinez re Treatment Codes vs. Med-legal, attached thereto are: e-mail note from Luisa Martinez to

Linda Rudolph, dates 1/30/97, re existing code for treating physicians, CPT 99080; ltr. marked TO WHOM IT MAY CONCERN, dated 7/12/94, from ENGLAND, HODIK & TROVILLION in San Diego, on the issue *Should the final comprehensive medical report of the primary treating physician be paid at medical-legal rates?;* Minutes of the OMFS Advisory Comt. Meeting held at the Marriott Hotel, LAX, on 12/13/96

Ltr. to Jacqueline Schauer, dated 3/25/97, from John H. Hoffman, Jr., President/CEO of Integrated Healthcare Recovery re a ltr. Jackie had faxed to Iva Loomis of Beech Street re reasonable maximum fees for medical services, L.C. §5307.1 vs. agreed contrated higher rate.

- Faxed memo from Susan McKenzie, M.D., IMC, dated 12/3/96, to Casey Young, A.D., DWC, re Ground rule 1(g) in the Physical Medicine Section of the OMFS, excerpt from American Medical Assn. print of OMFS along with questions

#26 OMFS/Media

- An excerpt from CMA newsletter (?) which states that 'State Backing Off From Raising Workers' Comp Fee Schedule'

#27 OMFS/MFCC

- News release (?) from Center for Occupational Psychiatry proposing an amendment to the existing fee schedule
- Ltr. from Roy Curry, M.D., dated 3/25/97, to Casey Young re psychiatric rates

#28 OMFS/Miscoding

- Memo from Linda Rudolph and Richard Sommer, dated 10/25/96, to the OMFS Advisory Committee covering the informal mtg. held 10/7th to discuss long-standing concerns regard the miscodding of medical bills.
- Memo (2) to Casey Young, dated 10/8/97, same as above Comparison table - 1995 Downcoding Results

#29 OMFS/networks

- Ltr. to Assemblyman John Burton, dates 10/30/97, from Linda Rudolph, M.D., Medical Director, discussing ltr. received from California Advanced Imaging which raised concerns over the proptness of network reimbursements

#30 OFMS/Nurse PA

- Ltr. to Casey Young, dated 3/14/97, from Dr. Lubow, re OMFS Reimbursement For Services Rendered by Physician Extender
- PAYOR POSITION PAPER ON EVALUATION AND MANAGEMENT CODE 2 copies (Background, Issue, Positions of Adv. Comte.)
- Ltr. from Dr. Philipp Lippe of the California Association of Neurological Surgeons, Inc., dated 3/21/97, to Casey Young re OMFS Reimbursement for Services Rendered by Physician Extenders
- Excerpts faxed from the California Society of Internal Medicine (book) to Linda Rudolph, M.D. re PA & NP reimbursement

#31 OMFS/Opthalmology

- Fax from Barbara Baldwin of CSIM, dated 11/6/96, to Diane Przepiorski, COA, indicating she couldn't attend the fee schedule meeting the next day,but sent clarification on remaining questions regarding ophthalmology codes.

#32 OMFS/Osteo

- Memo from Rosemary Payne, dated 10/10/96, to Linda Rudolph re APTA letter of 8/28/96, attached, comparing different years' codes.
- Ltr. from Karen Beckstead of Medicode, dated 4/9/97, to Susan McKenzie, IMC, regarding relative values of Osteopathic and Chiropractic manipulation codes
- Excerpts from the Business and Professions Code, high-lited §2051 (Physician's and Surgeon's Certificate) as well as §2453 (M.D. and D.O. Degrees-Equal Status)
- Ltr. to the Members of Council, dated 5/2/97, from Matt Weyuker of OPSC, re clarifying an issue daised during the most recent mtg on manipulation codes
- Ltr. to Casey Young, dated 4/3/97, from Matt Weyuker of OPSC - overview of approach taken at the mtg. 3/19/97 re fee schedule and ground rules which apply to all Osteopathic Manipulative Treatment codes with printout of public comments on HOT OR COLD PACKS (97010)
- Ltr. to Casey Young, dated 7/2/97, from Matt Weyuker of OPSC - follow-up to past converstaions as well as his testimony re OMFS and reimbursement for Osteopathic Manipulative Treatment at recent IMC mtg. (attached *Position Paper*, dated January 1997)

#33 OMFS/physical medicine

- Ltr. to Casey Young, dated 3/6/97, from Rea Crane, CWCI, transmitting three Payor Positions
- Ltr. to Casey Young, dates 3/6/97, from Bill Hutchins of APTA, providing comment on the proposed changes to the Physical Medicine and Rehabilitation Section of the OMFS (two copies)
- Ltr. to Drs. MacKenzie and Susan McKenzie, IMC, dated 2/17/97, from OPSC provided several proposal for consideration at the upcoming comte. mtg. to be held 2/20-21/97 since a number of his members were unable to attend.
- 1997 RBRVS Unit Values for PM, Osteo, Chiro Manipulations

#34 OMFS/Physical Medicine

- E-note attaching Federal Register, dated December 8, 1995 for Medicare Program; Physician Fee Schedule for Calendar Year 1996, from Linda Rudolph to Liza Dizon

#35 OMFS/Policy

- Memo, dated 10/25/96, from Luisa Martinez, I&A Officer, to Jackie Schauer, Linda Rudolph and Rosemary Payne re CPT code 99455

#36 OMFS/Prior Auth.

- Various sections of codes printed 4/25/97

#37 OMFS/Psych.

- Ltr. from Bob Larsen, M.D. of the Center for Occupational Psychiatry to Casey Young transmitting three position statements from the Industrial Medical Council Psychiatric Advisory Committee concerning the issues of missed appointments, psychiatric crisis intervention and medical psychotherapy

#38 OMFS/Psych. crisis

- Statement from Mr. Larsen of the Center for Occupational Psychiatry re Psychiatric Crisis Intervention: Need for Modifier-98.

#39 OMFS/PT

- Ltr. from Linda Rudolph, M.D., dated 11/26/96, to Cresswell Physical Therapy in response to two ltrs. rec'd, dated11/5

& 18/96 requesting interpretation of ground rule 1g (those ltrs. not enclosed in file)

- Ltr. from Linda Rudolph, M.D., dated 10/9/96, to Sandra Ligon of San Marcos Physical Therapy, clarifying secion (g) of the OMFS (p.404)
- Ltr. faxed to Casey Young, dated July 31, 1996, addressing the discrepancies posed by statements of Luisa Martinez and Rosemary Payne re reductions for Physical Therapist, p.404, section (g) of the Physical Medicine Section of the OMFS
- Ltr. from Linda Rudolph,M.D. dated 9/5/96, to Bill Hutchins of American Physical Therapy Associaton, re OMFS Physical Medicine Ground Rule1g

#40 OMFS/Physician comments

- Ltr. from Dr. R.E. Myers, Med. Dir. of Facey Occupational Medicine Ctr., dated 6/9/97, to Casey Young re him being an employer of over 400 people and wanting an outside provider to care for his injured employees rather than have them seen in-house

#41 OMFS/RBRVS

- Excerpts from *Annual Report to Congress,* Appendix A, pp. 399-408, Use of Medicare Fee Schedule Policies by Other Payers
- Copy of Workers' Comp Managed Care newsletter highlighting 'States More to RBRVS-Based Fee Schedules for Workers' Comp'
- Agenda (2) of OMFS Advisory Comtte. Mtg. dated 7/18/96
- RBRVS Subcommittee Roster List
- Sign-in sheet for the RBRVS Subcommittee w/ attachments:
  - * RBRVS Survey from Rosemary Payne to Linda Rudolph, dated 6/26/96
  - * Memo from Cynthia Robinson, dated 6/26/96, to Linda Rudolph re Medicare Fee Schedule - Legislative Intent
  - * Printout from the Melvyl System, Jun 13, 1996, re 78 citations in the Medline database
- Copy of WCRI Research Brief July 1996 - Volume 12, Number 7 covering the RBRVS as a Model for Workers' Compensation Medical Fee Schedules: Pros and Cons
- Excerpts from Health Care Financing Review/Winter1994/Volume 16, Number 2 re Difusion of Medicare's RBRVS and Related Physician Payment Policies
- Contact Note - Q&A re Medicare Fee Schedule from Cynthia Robinson of DWC to Ruth Berger of DOL, OWCP, dated

9/20/96

- Summary of Fee Schedule Advisory Committee Meeting dated July 18, 1996 at the SSF-Grosvenor Hotel with attached hand-written notes from IMC dated 9/19/96
- Memo from Cynthia Robinson and Linda Rudolph, M.D., of the DWC Medical Unit, dated 9/4/96, to Richard Sommer on the subject of Adoption of a Resource-Based RVS Fee Schedule
- Memo from Cynthia Robinson, dated 7/1/96 to the MFS Project File re History of South Carolina and Minnesota with Annual Report to Congress by the Physician Payment Review Commission
- Memo from Cynthia Robinson, dated 9/96, to Linda Rudolph re her contacts in gathering the RBRVS history (above)
- Excerpts from *For the Record* by Cheryly McCurdy, Communications Dept. of Crawford & Company in Atlanta, GA covering the Pensylvania's RBRVS-Based Fee Schedule
- Excerpts from the *Medical Economics•Pediatrics Edition•August 1994* re How many third parties will buy into RBRVS?
- Copy of the DWC Newsline - Clarification of Issues Concerning the Official Medical Fee Schedule
- Fee Schedule Benchmark Analysis from the Workers Compensation Research Institute/Cambridge, MA

#42 OMFS/Revisions

- DRAFT : DWC 6/3/1997 Changes to the California Official Medical Fee Schedule as Proposed
- Susan McK. comments, dated 5/1/97, re SECTION: General Information and Instructions for Use
- Additional changes, April 16, 1997

#43 OMFS/RVS

- Memo from Susan McKenzie, M.D., dated June 13, 1997, to Casey YOung and Linda Rudolph, M.D. covering relative values

#44 OMFS/SCIF

- Ltr. from Lisa Middleton, Claims/Rehabilitation Manager of SCIF, dated 6/19/97, to Allan MacKenzie, M.D., IMC, conveying the ltr. by Gideon Letz (attached) is his personal perspective and not a recommendation or expression of policy (re RBRVS) on behalf of State Fund
- Ltr. from Dr. Jeffrey Coe, dated 4/24/97, to Casey Young conveying his support to the vast majority of proposed

changes
- Ltr. from Dr. Rudolph, dated 6/27/97, to Diane Przepiorski of California Orthopaedic Association clarifying the confusion which has recently arisen regarding the Surgery Section of the OFMS
- Same ltr. above to CorVel Corporation, Attn: Feddie Tiamzon

#45 OMFS/Verbal Auth.

- Position Paper on Providers' Viewpoint on the Confirmation of Verbal Authorization for Payment by Diane Przepiorski, California Orthopaedic Assn.
- Ltr. from Brenda Ramirez, SCIF, dated 3/4/97, to Casey Young on the subject Payor Position on Confirmation of Verbal Authorizations (2 copies)

#46 OMFS/VR

- Ltr. from Casey Young, dated 11/26/96, to Jack McCleary, M.D., President of California Medical Assn., in response to his recent ltr. concerning the need for an increase in the conversion factors (ltr. not in file). Attachment: copy of an article entitle *Why is the Treatment of Work-Related Injuries So Costly? New Evidence from California*
- A fax from CA Orthopaedic Assn. - Confirmation of Authorization for Payment; Proposed language on Conformation of Authorization for Payment; Note for John P. from Linda R. re OMFS advisory comte mtg. held 'yesterday'

#47 OMFS/WCIRB

- Copy of Workers' Compensation Insurance Rating Bureau newsletter: TO THE MEMBERS OF THE ACTUARIAL COMMITTEE - final report on the Evaluation of the Cost Impact of the 1994 Medical Fee Schedule

Specific Technology or Equipment

This proposal will not mandate use of specific technologies or equipment.

Alternatives to the Regulation

The *Recommendation of Task Force on Official Medical Fee Schedule (March 1997)* details the various discussions and disagreements on alternative CPTs, RVs, conversion factors, modifiers and ground rules. Aside from the Task Force Report,

no alternatives to the amendments proposed have yet been identified or considered by the Administrative Director. It is the purpose of the present rulemaking process to solicit and consider alternatives.

Alternatives that Would Lessen Adverse Impact on Small Businesses

The *Recommendation of Task Force on Official Medical Fee Schedule (March 1997)* details the various discussions and disagreements on alternative CPTs, RVs, conversion factors, modifiers and ground rules. Aside from the Task Force Report, no alternatives to the amendments proposed have yet been identified or considered by the Administrative Director. It is the purpose of the present rulemaking process to solicit and consider alternatives.

PROPOSED CHANGES TO UTILIZATION REVIEW TITLE 8, CALIFORNIA CODE OF REGULATIONS SECTIONS 9792.6

General Problem Addressed by Proposed Action

Poor communication between physicians and claims administrators in the workers' compensation system has been a constant source of frustration, mutual mistrust, inefficiency and expense. Physicians complain that administrators often fail to respond to requests for authorization of proposed medical treatment, that they arbitrarily rescind authorization, that they deny authorization without cause, that claims adjusters – not physicians – are making medical decisions, and that physicians often simply do not know whether treatment is authorized or not. Claims administrators complain that physicians do not give adequate information on their treatment plans for the administrators to make a decision. Among other bad effects, this poor communication has led to a great number of medical-legal disputes (which are expensive procedures) and to a flood of lien disputes that has clogged the Workers' Compensation Appeals Board for years.

To address these problems, the legislature enacted Labor Code Section 139(e)(8), which requires the Administrative Director to "provide utilization review standards." Utilization review [UR] is the method by which claims administrators in the workers' compensation system decide whether to authorize medical treatment proposed by physicians. Utilization review standards were first promulgated in 1995 in 8 Cal. Code Regs. Section 9792.6.

The past two years' experience with these UR standards has not been altogether happy for either claims administrators or physicians. Many important questions were left unanswered in the original regulations. Most important, lines of communication are still uncertain.

General Purpose and Basis of Proposed Action

The present proposal is the first revamping of the UR system. It attempts to enhance communication by more clearly defining the duties of both sides and by providing unambiguous forms for communication.

Particular Problems Addressed by Proposed Action

1(a) Problem: Uncertainty on the Relationship Between the UR System and the Medical-Legal System

Labor Code Section 4062 requires administrators who dispute the need for particular medical treatment to serve an "objection" on the injured employee (not the physician). This "objection" commences the long and very expensive medical-legal process, which includes a medical-legal evaluation, or two such evaluations, followed by a hearing before the Workers' Compensation Appeals Board. There is uncertainty in the present UR system as to whether an administrator who denies a request for authorization must also file an "objection," or is excused from filing an "objection."

1(b) Purpose and Basis of Action: Define the Relationship: Medical-Legal Procedures are *Not* Required When an Administrator Uses the UR System to Deny Authorization, Unless the Physician Responds to the Administrator's Tentative Denial in Writing

One of the major purposes of the UR system is to avoid medical-legal procedures, to enable the parties to communicate about and agree on medical issues without litigation. Under the proposed regulations, a claims administrator *could,* at any point within the time limits of Section 4062, serve an "objection" and initiate the medical-legal process. In fact, we propose a form (PR-10) that an administrator would use to inform the physician that treatment is denied and the medical-legal process has commenced.

But in the usual case, the administrator should be able to inform the physician that, based on medical criteria, "the proposed treatment does not appear to be reasonably required to cure or relieve." (Proposed Form PR-11.) The physician then has the opportunity to discuss the matter with the reviewer and submit further evidence or state a disagreement with the criteria. But if the physician agrees with the reviewer's assessment of the case, no purpose is served by the medical-legal process. It should not be necessary for an administrator to invoke that process unless there is a real dispute. The proposed regulations therefore state unequivocally that when the administrator uses the new Form PR-11 to inform the physician of its tentative assessment, it is *not* necessary to serve an "objection"

under Labor Code Section 4062. In that situation, the UR system has effectively replaced the medical-legal system.

When a treating physician does disagree with the reviewer's tentative assessment of the case, and so informs the administrator in writing, then there *is* a genuine dispute on the issue – and the administrator must begin the medical-legal process by serving an "objection."

The underlying principle here is that a properly functioning UR system enhances communication and avoids medical-legal procedures. But if a genuine dispute remains, then the medical-legal system must be used.

2(a) Problem: Uncertainty on the Effect of the Failure of a Claims Administrator to Respond to a Request for Authorization

The present regulations require administrators to respond to a request for authorization with a written "authorization, denial, or notice of delay." It often happens, however, that the administrator does none of the above, but simply does not respond at all. In that situation, has the proposed treatment been approved or disapproved? If the physician gives the treatment, can the administrator claim later that the treatment was not "medically necessary" and refuse to pay?

2(b) Purpose and Basis of Action: Define the Effect: An Administrator's Failure to Respond is an Authorization

When a physician submits a treatment plan or other request for authorization, the physician is entitled to a response. If the administrator fails to respond, the physician may treat that failure as an authorization and proceed to give the proposed treatment.

On those rare occasions when an insurer's failure to respond was for some good cause, the insurer may nonetheless contest the medical necessity of the treatment rendered by demonstrating, through clear and convincing evidence, (a) that its failure to respond was indeed for good cause, *and* (b) that the medical treatment was *plainly* unnecessary.

3(a) Problem: Uncertainty on the Effect of the Failure of a Physician to Respond to an Administrator's "Denial" of Authorization

The present regulations impose duties on the claims administrator if a physician "has not *agreed* to the denial or reduction" (emphasis added). But what constitutes a physician's agreement? And how is either an agreement or disagreement communicated to the administrator?

3(b) Purpose and Basis of Action: Define the Effect: A Physician's Failure to Respond to an Administrator's Tentative Assessment is a Withdrawal of the Request for Authorization

The proposed regulations would mandate the use of a new Form PR-11 by claims administrators. PR-11 would be used when a request for authorization has been reviewed and there has been a tentative assessment, based on medically-based criteria, that the proposed treatment is not medically necessary. The claims administrator sends the PR-11 to the treating physician, informing the physician that "the proposed treatment does not appear to be reasonably required to cure or relieve." PR-11 gives the name and phone number of a reviewing physician and invites the treating physician to discuss the case with the reviewer. PR-11 also invites the treating physician to supply more evidence or simply to state his or her disagreement with the reviewer's tentative assessment.

If a physician fails to respond to the PR-11, it will be presumed that the physician's request for authorization has been withdrawn.

But if the physician makes *any* written response to the PR-11, there will no such presumption, and the administrator must either authorize the treatment or commence medical-legal proceedings.

4(a) Problem: Is Partial Authorization Possible?

It happens fairly often, especially in physical medicine and psychotherapy, that the treating physician submits an open-ended treatment plan, suggesting that the injured worker receive a very long series of treatments. An administrator might be willing to authorize, say, a month of treatment, and then review the worker's progress – but not be willing to authorize a lengthy or unlimited course of treatment, stretching perhaps for years. When an administrator authorizes treatment for some length of time, but not the whole time requested by the physician, is that an "authorization" or a "denial"?

4(b) Purpose and Basis of Action: Define the Effect of a Partial Authorization: A Partial Authorization is Permitted to Limit the Duration of Initial Treatment and Re-evaluate Need for Further Treatment after Intial Treatment.

The proposed regulations would allow an administrator to authorize treatment for a period of time less than requested by the physician. In that situation, it would not be necessary for the administrator to serve an "objection" under Section 4062. The physician is invited to send more information, which would usually be a statement of the worker's progress and, if necessary, a request for further treatment. Again, Form PR-11 is used.

5(a) Problem: How are Telephonic Requests for Authorization to be Handled?

The UR system as it now stands concerns written communications only – written requests for authorization and written authorizations or denials. But it is very common in the workers' compensation system for physicians simply to telephone the claims administrator from the physician's office – often with the patient actually present. This may be necessary if the patient needs care urgently. It may also be convenient for all parties if the request is a simple one. For instance, if the employee is sent to the physician only for an initial evaluation, and it becomes clear to the physician that some simple procedure, such as an injection, would actually cure the medical problem, then a telephone call should suffice to obtain authorization for the treatment.

Many physicians complain, however, that they obtain verbal authorization on the telephone, which claims administrators later deny having given. Allegedly, some administrators even rescind telephone authorizations after treatment has been rendered. In other words, physicians feel they cannot always *rely* on telephone authorization.

5(b) Purpose and Basis of Action: Require Claims Administrators, on the Physician's Request, to Give Written Confirmation of Authorization

The present proposal would allow for telephonic request, but would not relieve the physician of his or her duties concerning written reports. For instance, a physician might telephone an administrator to get authorization for an injection; but the physician would still have to file a "Doctor's First Report" or other appropriate report.

A claims administrator could deny a telephone request for any reason. If, for instance, the adjuster felt that he or she did not have enough information to make an on-the-spot decision about medical necessity, the adjuster could simply deny the telephone request. The issue of medical necessity would then be raised later, when the physician filed a written treatment plan.

A claims administrator could also grant a telephone request. The proposed regulations would allow the physician to request a reliable confirmation of the administrator's authorization. The administrator would be required to give that confirmation. It could take the form of a unique authorization number given over the telephone. Or it could be a written authorization provided by mail, FAX or e-mail. The confirmation does not need to be elaborate. In fact, the new single-page form PR-12 is designed to serve as such a confirmation. But this written confirmation would memorialize the authorization, give certainty, and avoid later disputes.

Documents Relied Upon

Utilization Review Accreditation Commission / Association for Accreditation of Ambulatory Health Centers, *Utilization Review Accreditation Standards for Workers' Compensation* (1995).

Rulemaking file for adoption of 8 Cal. Code Regs. Section 9792.6, effective July 20, 1995.

Specific Technology or Equipment

This proposal will not mandate use of specific technologies or equipment.

Alternatives to the Regulation

No alternatives to the amendments proposed have yet been identified or considered by the Administrative Director. It is the purpose of the present rulemaking process to solicit and consider alternatives.

Identified Alternatives that Would Lessen Adverse Impact on Small Businesses

It is not anticipated that there will be any adverse impact on small businesses. No alternatives which would lessen the impact have been identified or considered by the Administrative Director. It is the purpose of the present rulemaking process to solicit and consider alternatives.

Evidence Supporting Finding of No Significant Adverse Economic Impact on Any Business

The clarification of these utilization review regulations to improve communication between physicians and claims administrators cause some temporary inconvenience to physicians and claims administrators as they learn the new system to use new forms. However, the Administrative Director has determined that there will be no significant adverse economic impact on either physicians or claims administrators. On the contrary, there may be a significant beneficial impact through improved communications and the avoidance of disputes that must now be handled through expensive medical-legal procedures.

PROPOSED CHANGES TO THE MEDICAL-LEGAL FEE SCHEDULE TITLE 8, CALIFORNIA CODE OF REGULATIONS SECTIONS 9795

Please note that the Medical-Legal Fee Schedule "establishes or fixes rates, prices, or tariffs" within the meaning of Government Code Section 11343(a)(1) and hence is

not subject to Article 5 of the Administrative Procedure Act (commencing at Government Code Section 11346.) Nonetheless, the Administrative Director of the Division of Workers' Compensation gives this Initial Statement of Reasons in voluntary compliance with the Administrative Procedure Act.

General Statement of the Problem Addressed by Proposed Action

Labor Code Section 5307.6 requires the administrative director [AD] of the Division of Workers' Compensation [DWC] to "adopt and revise a fee schedule for medical-legal expenses, as defined by Section 4620. . . at the same time he or she adopts and revises the medical fee schedule pursuant to Section 5307.1." The medical fee schedule is being revised at the present moment.

General Statement of the Purpose and Basis of Proposed Action

The proposed amendments to the medical-legal fee schedule [MLFS] are to comply with the requirement of Labor Code Section 5307.6 that revisions to the MLFS be made simultaneously with revisions to the medical fee schedule. The present proposals are based on the work of the Medical-Legal Fee Schedule Task Force, a public advisory body convened by the Industrial Medical Council pursuant to Labor Code Section 139(e)(7) and the Administrative Director pursuant to Labor Code Section 5307.1(a)(3). In the introduction to its report to the Administrative Director, the Task Force explained its purpose and methods as follows:

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This volume contains the recommendations of the Medical-Legal Fee Schedule Task Force. (MLFS Task Force), a public advisory body convened by the Industrial Medical Council and the Division of Workers' Compensation to assist in the revision of the California workers' Compensation medical-legal fee schedule (8 C.C.R. §9795). This Task Force was formed in parallel with a Task Force to revise the California workers' compensation official medical fee schedule. The recommendation of that Task Force are the subject of a second volume.

Both Task Forces were convened pursuant to authority granted to the Industrial Medical Council and the Administrative Director by the Labor Code. Labor code sections 139(e)(7) and (8) direct members of the Industrial Medical Council within the scope of each member's professional training: (a) to recommend reasonable levels of fees for physicians performing services under Division 4 of the Labor Code; and (b) in coordination without he Administrative Director, to monitor and measure changes in the cost and frequency of the most common medical services. Labor Code Sections 5307.1 and 5307.6 direct the Administrator Director of the Division of Workers' Compensation to adopt the official medical and medical-legal fee schedules no less frequently than biennially.

The MLFS Task Force met monthly between June, 1996 and January, 1997, in locations which alternated between northern and southern California. All meetings were publicly noticed and were open to any member of the workers' compensation community who wished to attend. Notice of the intent to hold meetings was sent to participants in previous DWC fee schedule advisory committees; to those on the IMC's mailing list and its lists of professional organizations; and to representatives of the payer and employer communities. The meetings were hosed and supported by the Industrial Medical

Council and were facilitated by Allan MacKenzie, M.D., its Executive Medical Director. Meetings were generally attended by approximately forty individuals.

As its initial task, the MLFS Task Force developed the mission statement in Section 2 of this report. The Task Force identified and prioritized items for discussion at its meetings and set its own meeting schedule. Minutes taken at each meeting were disseminated to participants and to a larger "by request" mailing list. The Task Force was advised by the Administrative Director that all issues pertaining to the medical-legal fee schedule were "on the table".

Subcommittees were formed to ease the work of the full Task Force and to report recommendations to the full committee for adoption or resolution. All subcommittee meetings were open to those who wished to attend. Many of the difficult negotiations were undertaken in subcommittee. The work product of the EOB (now WOR) Subcommittee resulted in the proposed optional "Explanation of Review" messages found in Section 6. The work of the MLCS Subcommittee resulted in a recommendation for further study of the impact of institution the proposed Medical-Legal Complexity Scale. The work of the Conversion Factor Subcommittee resulted in a decision to advance pro and con arguments for changing the conversion factor to the public hearings.

The Task Force's procedure for identifying consensus evolved. Initially, the Task Force chose to vote using a simple hand count (straw vote), believing it would be clear when consensus did not exist. Consensus votes in early meetings are therefore labeled "consensus" in the minutes. As the Task Force grew and the issues became more complex, the names of dissenting organizations and reasons for dissension were documented. In September, the Task Force adopted a two-tiered voting procedure, using an "A Vote/B Vote" plan to eliminate the potential bias which occurred when organizations had more than one representative in attendance. Each organization or entity was provided with a placard with the organization's name. For each item voted upon, an initial straw vote ("A Vote") was obtained. Any member of the Task Force could also call for a "B Vote" in which each organization/entity was entitled to only one vote (by placard). For "B Votes", the names of all who voted (In Favor; Opposed; Abstaining) were recorded in the minutes. Consensus was generally considered to have been reached when two-thirds of the vote was affirmative.

Task Force participants have collectively spent thousands of hours in preparation, meetings, and discussions to resolve issues of concern. Many issues were resolved through this consensus driven process and are reflected in the proposed draft of the medical-legal fee schedule in Section 3. Not unexpectedly, some issues remain unresolved: most notably, that of changing the conversion factor. Position papers from providers and payers on the pros and cons of changing the conversion factor appear in Section 5. In addition, the minutes of each meeting document the dialogue and concerns of stakeholders on each of the issues.

The Industrial Medical Council wishes to express its appreciation to all who participated in the work of this Task Force and to the organizations and entities who supported the participants. The chairpersons of the subcommittees deserve special recognition for accepting these laborious leadership positions.

The Administrative Director has followed all the recommendations of the Task Force, except one. The Administrative Director has declined to follow the Task Force's recommendation that missed appointments be reimbursed at the rate of $200.

Particular Problems Addressed by the Proposed Action
Together with the Purpose and Basis of Each Proposed Action

1(a) Problem: The Present MLFS Does Not Have a Code for Physicians to Indicate Missed Appointments

When a patient makes an appointment, the physician sets aside time for see the patient. When the patient fails to keep the appointment, the physician may or may not lose money, depending on the situation. At present these is no code to indicate a bill submitted to the payer in this situation.

1(b) Proposed Action: Provide a Code to Indicate Missed Appointments

The proposed MLFS includes a new code – ML100 -- for missed appointments. No relative value is given since, by definition, no medical-legal services have been performed. The physician therefore will charge "By Report." Any reimbursement will be determined by the parties. The code is designed solely as a convenient method of communication between provider and payer.

(2)(a) Problem: Single Fee for Follow-Up Evaluations

The MLFS now reimburses for follow-up medical-legal evaluations (ML101) at the maximum rate of $250, regardless of the amount of time and effort spent on making the evaluation.

Initial medical-legal evaluations (ML 102, 103 and 104) *always* involve significant time by the physician. The physician must address all medical issues in and must meet stringent requirements, including the taking of a complete history, review and summary of prior medical records, specific findings on factors of disability, apportionment, medical treatment, etc. By contrast, follow-up evaluations may be very brief indeed, taking perhaps no more than a few minutes to bring one portion of an evaluation up-to-date. Other follow-ups may require more time, including, perhaps, a physical re-examination of the injured worker and review of lengthy new medical records. A single fee of $250 for all follow-up evaluations will often be too great or too small.

2(b) Purpose and Basis of Proposed Solution: Reimburse Physicians in 15-minute Increments

It is proposed to amend Code ML101 to state that follow-up evaluations shall be billed by time in 15-minute increments. Each increment would have a relative value of 5 (instead of the present 25), which would be multiplied by $10. In other words, the maximum rate which a physician could charge would be $50 for each quarter hour. A follow-up evaluation that took one hour would be billed at $200 -- $50 less than the present maximum fee. An evaluation that took one-and-a-half hours would be billed at $300 -- $50 more than at present.

3(a) Problem: "Complexity Factors" for Complex Evaluations are Inadequate

If an initial medical-legal evaluation is "complex," the physician uses Code ML103 and may bill at a higher rate than for a "basic" evaluation under ML102. If the evaluation involves "extraordinary circumstances," the physician uses Code ML104 and may bill still higher. An evaluation is "complex" if three factors are present. There are six possible factors: (1) two or more hours of face-to-face meeting with the patient, (2) two or more hours of record review, (3) two or more hours of medical research, (4) whether the evaluation addresses the issue of medical causation, (5) whether the evaluation addresses the issue of apportionment, and (6) whether the evaluation concerns a worker who has been exposed to a toxin.

These factors are insufficient. First, there may be situations where a physician must spend, say, 4 hours in face-to-face examination, but only 1 in record review. The total time spent is 5 hours, but the physician is only entitled to one factor: the factor for a two-hour face-to-face examination. This may be compared to a physician who spends only 2 hours in a face-to-face examination and 2 hours in record review, for a total of 4 hours. This second physician may claim two complexity factors, instead of one, although in fact he or she spent less total time than the first physician. This is an unfortunate anomaly.

Second, psychiatric and psychological evaluations very typically require reports of great length by some of the most highly paid members of the medical profession.

3(b) Purpose and Basis of Proposed Solution: Add "Complexity Factors" to ML103 and 104

It is proposed to add three complexity factors. The first two would permit hours to be aggregated. For instance, 3 hours of face-to-face examination could be added to 1 hour of record review to equal 4 hour in aggregate, which would be equal to 2 "complexity factors." Likewise, 4 hours of face-to-face examination plus 1 hour of record review plus 1 hour of medical research would aggregate to 6 hours, which would be equal to 3 "complexity factors.

It is also proposed to add one complexity factor for a psychiatric or psychological evaluation.

Documents Relied Upon

Recommendation of the Medical-Legal Fee Schedule Task Force (February 1997) , including sub-committee reports and other documents contained therein.

Minutes of OMFS/MLFS Task Forces Committee Meeting, March 19, 1997.

Specific Technology or Equipment

This proposal will not mandate use of specific technologies or equipment.

Alternatives to the Regulation

The *Recommendation of the Medical-Legal Fee Schedule Task Force (February 1997)* details the various discussions and disagreements on the matters contained in this Initial Statement of Reasons, including the possibility of raising the conversion factor for medical-legal evaluations, which was rejected. Aside from the Task Force Report, no alternatives to the amendments proposed have yet been identified or considered by the Administrative Director. It is the purpose of the present rulemaking process to solicit and consider alternatives.

Identified Alternatives that Would Lessen Adverse Impact on Small Businesses

No adverse economic impact on small businesses is anticipated, since the only small businesses affected, as defined by Government Code Section 11342(h), appear to be individual medical practitioners. Aside from the Task Force Report no alternatives which would lessen the impact have been identified or considered by the Administrative Director.